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ABSTRACT

This document is intended to provide guidance in the delivery of motor services to Colorado students with impairments in movement, sensory feedback, and sensory motor areas. Presented first is a rationale for providing adapted physical education, occupational therapy, and/or physical therapy services. The next chapter covers definitions, qualifications, and roles of the adapted physical educator, the occupational therapist, the physical therapist, and paraprofessional in such areas as decision making, program management, liaison, and direct support service. Identification of needs is considered next, including screening, the Child Study Conference, and referral to special education. The discussion of the assessment process briefly reviews functional assessment and neuromotor/developmental assessment. A subsequent chapter looks at staffing and the development of the Individualized Education Program including team composition, determining needs, establishing annual goals, placement recommendations, and assignment of personnel. The last three sections briefly cover delivery systems, documentation, and caseloads. Eight appendixes include certification standards, an assessment outline, severity rating scales, checklists, terminology, a list of tests, and a nine-item bibliography. (DB)

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THE ROLE OF ADAPTED PHYSICAL EDUCATION, OCCUPATIONAL THERAPY, AND PHYSICAL THERAPY IN MEETING THE MOTOR NEEDS OF STUDENTS WITH HANDICAPPING CONDITIONS IN EDUCATIONAL SETTINGS

PROCEDURES MANUAL

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ADAPTED PHYSICAL EDUCATION, OCCUPATIONAL THERAPY AND PHYSICAL THERAPY IN THE PUBLIC SCHOOL

PROCEDURES AND RECOMMENDED GUIDELINES

This manual was prepared by a committee of adapted physical educators, occupational therapists, physical therapists and administrators.

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Denver, Colorado, 1989

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PREFACE

This document was written by a committee of adapted physical educators, occupational therapists, physical therapists and administrators in response to a request from statewide special education administrators on how to provide motor services to students who have needs in the motor area. This document does not intend to define the potential roles of adapted physical educators, occupational therapists, and physical therapists, rather it is intended to serve as a guideline on motor service provision. Adapted physical educators, occupational and physical therapists should refer to their own professional organizations for guidelines on other areas of functioning.

These guidelines are intended for use in the educational environment, taking into consideration the unique situations that school systems present the student and the professional. If these guidelines had been written for psychiatric care centers or adult rehabilitation settings, they would look much different.

DEDICATION

This manual is dedicated to the memory of Dr. Jeanne Hughes whose work as a physical therapist was instrumental in promoting the use of adapted physical education, occupational therapy and physical therapy in meeting the motor needs of children. The children of Colorado are forever indebted to her leadership.

ACKNOWLEDGEMENTS

The Department of Education, Special Education Services Unit, wishes to acknowledge all task force members who spent so much of their time in developing this manual. Additionally, appreciation is given to all those states which shared with the Colorado Department of Education their policies, procedures and handbooks. In particular, the Department acknowledges the work of the Waukesha County Exceptional Education Cooperative in its **Waukesha Delivery Model: Policy and Procedures Manual** which provided the task force with ideas and directions. Finally, the Department acknowledges the contributions of faculty members of Colorado State University whose critique of the drafts contributed to the final document.

Special credit must be given to Jill Knapp for taking the ideas of the task force and translating them into a workable and readable format.

Special tribute must be given to Kathy Kini, Jody Ohmert and Kathy Werner for their work in transposing all the questionnaires and scales into this final format.

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I. INTRODUCTION

Children with handicaps in every school district have special problems. Some of the students with handicapping conditions may have a variety of needs in one or more of the the following areas: communication, cognition, social/emotional responses and physical functioning. Impairments in any of these areas may impede the child from attaining the goals inherent in the public school's regular curriculum. For this reason, state and federal regulations mandate the provision of appropriate educational services (instructional and related) to all handicapped children attending public schools.

Student needs that result from an impairment in any of the functioning areas must be met, if such impairment impedes or hinders the student from receiving an appropriate education. It is the responsibility of the staffing team to determine if a student's needs are educational, if the impairments impede the student's attainment of an appropriate education and if the public school is the responsible agency. The staffing team may include special educators, regular educators, parents, administrators, diagnostic personnel, physical therapists, occupational therapists, speech therapists and adapted physical educators, the child (if appropriate), and other individuals.

Colorado has adopted a "needs based" model for the provision of services to handicapped students. As indicated above, the educational needs of students with handicapping conditions are a result of an impairment or impairments in any or all of the following areas: communication, cognition, affect and/or physical functioning. In itself, physical functioning is divided into the following areas: health and movement (motor),and sensory motor components. **This document concerns itself with those needs that are a result of impairments in the movement (motor) area, sensory feedback, and the sensory motor area of physical functioning.**

Motor is that aspect of physical functioning which requires muscular control to perform activities. This includes the concepts of sensory motor, sensory feedback, stability, mobility, and the integration of these components into functional activities.

The decision making process becomes especially difficult regarding motor needs. What motor services should be provided? Who should provide the motor services? What is an adequate and appropriate service? How must a school provide the motor services? May this be done through a teacher or a paraprofessional? At what point does the school's obligation cease and the parent's begin? What are the differences between the different disciplines: adapted physical education, occupational therapy and physical therapy?

The purpose of this document is to assist local personnel in the decision making process for students with motor needs. It was developed in response to requests from local directors of special education who felt that there was a need for more direction.

This document will revolve around the assessment and staffing process and the individualized educational program for the student and how the determination of motor services fits into this process. The better the judgment of the staffing team, the better will be the individualized educational program for the student.

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II. RATIONALE FOR PROVIDING ADAPTED PHYSICAL EDUCATION, OCCUPATIONAL THERAPY AND/OR PHYSICAL THERAPY

The Special Education Services unit of the Colorado Department of Education subscribes to the philosophy that the purpose of education is to assist the student to be able to function as independently and productively in society as possible within the realm of his/her capabilities. In order for schools to accomplish this purpose, they have placed great emphasis on academic subjects. The assumption has been that by developing primarily the cognitive skills of a child, such child would be able to use his/her skills in becoming independent and productive in society. More recently, however, schools have begun to recognize that not all students have the ability to generalize from the concepts and skills which they may have learned through such a traditional approach. As a consequence, school systems are beginning to include function as part of the curriculum, increasing the probability that a child will be successful after his/her completion of public school experience. The Special Education Services Unit believes that all children with handicapping conditions must be provided with a curriculum appropriate to their needs.

In the past, school systems were able to assume that their primary role was to develop the cognitive skills of the child while the family and other agencies would address the child's social/emotional, physical and communicative needs. The interdependence of these functioning areas has made it very apparent that in order for school systems to accomplish their purpose, they must address all functioning areas. The Special Education Services Unit believes that children with handicapping conditions have a right to all those services, academic as well as nonacademic, which are necessary for the child to achieve the purpose of the educational system.

Traditionally, school systems were able to develop curricula in which the majority of children were able to achieve. Programs and subject areas were designed to be age appropriate. Children were placed in these programs and classes. Again, children with handicapping conditions often were unable to attain the expected outcomes of these programs or subject areas. School systems began to modify these programs and eventually turned to the development of individualized educational programs. In other words, school systems began to view each child with a handicapping condition as having unique abilities and needs. The role of the public school is to build on the student's abilities and to meet his/her needs.

Such diversity of abilities and needs requires diversity of services. Many different disciplines must work together to meet such needs. For this reason, therapists and teachers alike work together to "teach" the student what he/she needs to become as independent as possible in society. The Special Education Services Unit believes that children with handicapping conditions have a right to be "taught" by those professionals who are best qualified to meet the needs of the child.

Adapted physical educators, occupational therapists, and physical therapists play an important role in the educational process of children. For those students whose needs are as much in the sensory motor domain as in the cognitive, often the adapted physical educator, occupational therapist and/or physical therapist provide the "instruction" that will enable a child to function better within his/her capabilities across the different environments (school, home and the community). Furthermore, physical education, occupational therapy and physical therapy are services required by P.L. 94-142 for children with handicapping conditions and who otherwise would not benefit from their educational program.

In Colorado, adapted physical educators, occupational therapists, and/or physical therapists working within educational environments differentiate themselves from their peers in hospitals or private settings. This is accomplished by assessing and promoting the student's ability to function motorically at school, at home, and in the community since this is the projected outcome of the educational system.

These guidelines have been developed to focus on the problems encountered by students with needs in motor areas (movement, gross and fine motor); adaptations or adaptive equipment needs; perceptual motor needs; visual motor needs; or in the development of compensatory skills within their different environments. There are a variety of viewpoints as to when/how a student should be served to meet his/her physical needs in an educational setting. These opinions may stem from the student's therapists in outside agencies and/or from other health professionals, previous programs, parents and other professionals. The decision to provide physical education and educationally related services must be made by the staffing team through the staffing process.

III. ADAPTED PHYSICAL EDUCATORS, OCCUPATIONAL THERAPISTS, AND PHYSICAL THERAPISTS AS SERVICE PROVIDERS IN EDUCATIONAL SETTINGS

A. Explanation

It should be clearly understood that adapted physical educators, occupational therapists and physical therapists are individually unique. Each profession has its own professional preparation following different curricula and differing state and national registration requirements as well as certification within its own ranks. Each has specific areas of expertise to offer a student.

Since the person who is to provide the services is not determined until the end of the staffing process, school administrators should have an understanding of each profession to assist in the assessment and staffing process.

B. Definitions and Qualifications of Adapted Physical Educators in Educational Environments

1. Adapted Physical Educator (APE)

   a. Definition: The adapted physical educator is a trained professional who can assess individuals and groups of students and develop and implement adapted physical education programs for handicapped students. These programs may include remedial and developmental activities; physical fitness and endurance; games and sports; rhythms and dance; leisure and lifetime activities.

   b. Qualifications:

      1. The adapted physical educator must have a four year degree in physical education and a Colorado Teaching Certificate.

      2. It is strongly recommended that any individual employed to provide full time direct services

and/or consultant services in adapted physical education have a minimum of 12 semester hours in special education and/or adapted physical education.

2. Occupational Therapist (OT)

a. Definition: The occupational therapist is a health professional who utilizes the application of purposeful, goal-directed activity in the assessment and treatment of persons with disabilities. In an educational setting, the occupational therapist can use motor activities to facilitate:

- use of upper extremities;
- sensory motor integration;
- fine, visual and oral motor control;
- activities of daily living such as eating and dressing; and
- motor aspects of pre-vocational skills.

b. Qualifications:

1. The occupational therapist must be nationally certified by the Occupational Therapy Certification Board. Current experience in pediatrics is preferred.

2. The occupational therapist must have a Type E Certificate from the Colorado Department of Education or be eligible for a three year Provisional I Certificate. (Please refer to Certification Requirements in the Appendix).

3. Physical Therapist (PT)

a. Definition: "The physical therapist is a health professional concerned with providing assessment and habilitative or rehabilitative services to individuals to:

- prevent or minimize disability;

- relieve pain; develop and/or improve motor function and control;
- prevent/minimize postural deviations; and
- establish and maintain maximal performance within the individual's capabilities."[1]

(Included is adaptation of the environment and/or instruction in the use of adaptive equipment to promote improved function in the educational setting.)

b. Qualifications:

1. The physical therapist must have a current Colorado State license in physical therapy, with current experience in pediatrics preferred.

2. The physical therapist must have a Type E Certificate from the Colorado Department of Education or be eligible for a three year Provisional I Certificate. (Please refer to Certifications Requirements in the Appendix).

3. The current (1988) Physical Therapy Practice Law provides the public with direct access to physical therapists. Physician referrals/prescriptions are no longer required to receive physical therapy. Physical therapists are responsible for referrals of individuals to physicians when the patient's presenting problems require further medical expertise.

   School districts may still request individual physician referrals for students to clarify concerns, physical problems and to request indications and contraindications for interventions. It is beneficial for the physical therapist to receive current information of the physician's physical findings. The ideal situation would be the educational setting, family and physician working together as a team.

4. Paraprofessionals (COTA, PTA, Teacher Aides and Others)

a. Certified Occupational Therapist Assistant (COTA)

A Certified Occupational Therapist Assistant (COTA) is a health professional who has graduated from an American Occupational Therapy Association accredited Associate Degree Curriculum or an American Occupational Therapy Association approved Technical Curriculum; has completed supervised field work; has successfully completed the American Occupational Therapy Association national certification examination; maintains current registration and is supervised by a qualified Registered Occupational Therapist.

"Occupational therapy assistants must receive supervision from an occupational therapist as defined by the *Guide for Supervision of Occupational Therapy Personnel (Reference Manual,* 1986, pp. VIII-VIII.2) and as reflected in the *Guide to Classification of Occupational Therapy Personnel (Reference Manual, 1986, pp. VIII.3-VIII.10).* It is the responsibility of the supervising occupational therapist to ensure, according to existing role delineation, that these standards are enforced."[2]

b. Physical Therapist Assistant (PTA)

"A Physical Therapist Assistant is a health professional who has graduated from an educational program for the Physical Therapist Assistant accredited by the American Physical Therapy Association; is licensed to practice in the State of Colorado in accordance with licensure requirements and is supervised by a licensed Physical Therapist."[1] **The Physical Therapist must be on the premises while the PTA is performing his/her duties.**

c. Special Education Paraprofessional

A Special Education Paraprofessional is one who is assigned to assist and support the teacher or therapist, but who does not assume the primary responsibility for the instruction or therapy. This definition also applies to those paraprofessionals who may hold degrees and certificates but are employed to function as paraprofessionals.

C. Conceptual Roles of Adapted Physical Educators, Occupational Therapists, and/or Physical Therapists Within Educational Environments

Special Educators are required to assume a variety of responsibilities and roles to insure that the student with physical or functional needs receives benefit from the expertise provided these professionals. These roles and responsibilities include but are not limited to the following:

1. Decision Making

   a. Assessing the individual student within a team approach to determine the present level of functioning;

   b. Participating within the multidisciplinary and/or transdisciplinary team decision making process;

   c. Participating in the planning of the I.E.P. including the formation of long and short term goals and objectives;

   d. Designing programs for intervention to assist the student in achievement of the educational goals;

   e. Implementing program objectives; and

   f. Monitoring changes in the student and revision of the program as needed.

2. Program Management

   a. Determining an area or areas within the instructional environments to provide the necessary interventions;

   b. Recommending and obtaining the necessary equipment to provide the necessary intervention;

   c. Scheduling;

   d. Recommending intervention procedures designed to achieve the educational goals;

   e. Documentation of changes in the student;

   f. Evaluation of the program; and

   g. Discharge from motor service

3. Liaison

   a. A physical or occupational therapist may act as liaison between the medical and educational systems regarding the student's physical condition and the condition's effect on his/her learning and level of functioning;

   b. Physical and occupational therapists functioning in educational environments may also act as liaisons between privately based therapists and the educational system;

   c. Adapted physical educators may act as liaisons to the regular physical educators and classroom educators, as well as liaisons to physical therapists and occupational therapists; and

   d. Physical and occupational therapists may act as liaisons to the regular physical educators and classroom educators.

4. Direct Support Services

   a. Provide individualized assessment as part of a team approach which includes motor dysfunction and functional components as related to the motor dysfunction;

   b. Provide direct, hands on instruction/intervention to the student individually; in small group settings; in other situations within the educational environments to improve the student's functional motor performance level in accordance with the student's needs;

   c. Provide direct service to the student regarding adaptation of the environment; adaptive and/or rehabilitative equipment; positioning; orthoses, orthotics, etc. in accordance with the student's needs;

   d. Provide the student with an individualized home program designed to promote life-long maintenance of motor abilities;

   e. Teach the student to direct others to deal with their individual needs; and

   f. Develop and monitor a maintenance program for the student and train others to implement such program as needed.

5. Support/Resource/Collaboration

   a. Assist members of the instructional team in gaining an awareness and understanding of the student's functional levels relative to his/her ability to function within the instructional environments;

   b. Provide collaboration and assistance to parents regarding the student's handicapping condition and its effect on level of functioning at school, home and in the community; and

c. Assist in locating community resources when the therapy needed is not required to assist the student to benefit educationally.

6. Education

a. Provide inservice training for teachers, teacher para-professionals, administrators and other educational staff as necessary to increase awareness and understanding as well as develop intervention programs to be delivered by these service providers as appropriate;

b. Supervise university students in clinical rotations in their professional area (APE, OT and PT); and

c. Provide staff development.

7. Instructional

In some instances of early childhood intervention and/or classrooms serving the severe-profound needs, while functioning as part of a team, the occupational and physical therapists may provide instructional services to the student;

D. Variations in the Roles of Adapted Physical Educators, Occupational Therapists and Physical Therapists

A variety of roles for occupational and physical therapists exist within the medical community and the educational environment. Within the medical community occupational and physical therapists have more diverse roles. For instance, an occupational therapist working in a psychiatric setting or in an adult rehabilitation setting would place his/her treatment emphasis in different areas than he/she would do within the educational setting. The same is true for the physical therapist working in a general rehabilitation setting, hospital, or sports medicine clinic. Each has a variety of areas of expertise to offer (Please see appendix for roles). In pediatrics, specifically, there is significant overlap of the occupational therapy and physical therapy disciplines.

These guidelines are not intended as a definition of the potential roles of adapted physical educators, occupational therapists and/or physical therapists outside of the educational environment. The professional should look to his/her individual professional organization for further clarification of these roles.

The general goal for physical and occupational therapists is the same: to assist the student to succeed within the educational setting by minimizing the effect of a handicapping condition. The therapist's basic role is to organize, develop and implement a program involving the use of selected, constructive activities. Both occupational and physical therapists work to:

- develop physical prerequisites for functional skill development and coordination:
- improve impaired muscle strength and limit the impact of muscle deteriorating diseases:
- improve or maintain physical endurance impaired through physical injury or disease;
- improve functional independence by recommending and teaching use of adapted equipment and/or teaching other methods of compensation;
- educate staff, students, and families regarding each student's disability, motor needs, use of equipment, and so forth.

The role of the adapted physical educator is to develop body management, body mechanics, assist in the development of basic gross motor skills and coordination, assist in the development of perceptual motor skills.

Generally, physical therapists deal with overall body management, body mechanics, development of basic gross motor skills, ambulation, transfers, mobility and coordination as well as postoperative functioning and rehabilitation in an effort to return to

prior/improved functioning level. Occupational therapists focus more on fundamental skill development, adaptations to the environment, adapted equipment, upper extremity and hand rehabilitation, sensory integration for body awareness and skill development.

There is a degree of overlap in adapted physical education, occupational therapy, and physical therapy. These professionals use similar intervention philosophies to promote the development and improvement of functional skills. The similarities and amount of overlap between the three professions is probably greatest when working with a student who is more neurologically/orthopedically involved (cerebral palsy, spina bifida, head trauma). Similarities stem from the philosophy of promoting the integration of abnormal reflex patterns and more normalized movement patterns toward functional outcomes. However, the physical therapist's focus is toward more global, general gross motor development and ambulation/mobility. The occupational therapist's focus is toward finer functioning of the upper extremities and hands, activities of daily living, perceptual motor skills and adaptive equipment. The adapted physical educator's focus is on functional motor skill development and social skill development which can be applied to lifetime sports/games, recreational programs and fitness-conditioning programs.

Knowledge of the contraindications for any intervention should be considered before that intervention has begun. In all cases there is a great deal of cooperation among the professions in an effort to effectively meet the student's needs.

If the services of these professionals are not available to a school district, then an effort should be made to consult with other professionals who would most likely provide the service in other settings and with the physician and the parent before making decisions regarding a service.

IV. IDENTIFICATION OF NEEDS

A. SCREENING

Definition: 1). a process of surveying large numbers of children in an effort to identify those having previously undetected problems; and 2). a process of reviewing written or verbal information concerning a child in order to determine the need for assessment.

Adapted physical educators, occupational and/or physical therapists may be involved directly in screening as appropriate, or indirectly as consultants to other personnel who regularly screen students. Whether or not adapted physical educators, occupational therapists and/or physical therapists become involved in the screening process is a decision which the administrator of special education programs must make. This decision is made on the basis of how the system wishes to utilize these professionals. In most instances, systems prefer to utilize adapted physical educators, occupational therapists and physical therapists for the provision of services, leaving the screening process to others. In such instances, it is important that the screening process incorporate a consideration of those key elements which would identify problems and determine the need for assessment.

An important role of the adapted physical educator, occupational therapist and physical therapist is to ensure that screening methods used by the public school system are appropriate to the chronological, educational and the functional level of the student. Instruments should be used on the population for which they were developed and standardized.

B. INITIATION OF A CHILD STUDY CONFERENCE

The following strategies may be used by teachers and others as guidelines for referring a child to the Child Study Conference.

1. Use of a questionnaire which includes the concepts on page 19 .

2. Inability or difficulty performing age appropriate and/or ability appropriate gross motor, fine motor, expected daily living tasks or expected classroom tasks. Tasks should be appropriate to age and ability level, time efficient/effective, performed independently (if possible) and used spontaneously in the naturally occurring situation. These may include:

    - head control
    - rolling
    - sitting
    - crawling
    - walking
    - eating
    - holding a pencil or crayon
    - writing
    - cutting
    - running
    - dressing
    - toileting

C. CHILD STUDY CONFERENCE

Most often in public schools, before a child is referred to special education, a child study conference is conducted. The purpose of this conference is to assist the student experiencing problems which are significantly interfering with his/her ability to learn. It assists the classroom teacher in generating strategies for helping the student learn before referring the student to special education. While participants at this conference typically come from regular education, specialists may be invited to attend. The committee will develop alternative strategies to enable the child to learn in his /her regular environment whenever possible, or whenever necessary, tc facilitate the assignment of assessment responsibilities to the assessment team members. As part of this process, the adapted physical educators, occupational and/or physical therapists may be called upon. Referral to the child study conference may be made by educational staff members, support staff members, parents, physicians or community agencies.

In order to ensure consideration of all facets of the child's manner of functioning, it is recommended that each system incorporate into its process a series of questions that enable the administrator to decide whether or not an adapted physical educator, occupational therapist and/or physical therapist should be included in the process for the student in question. This questionnaire should be completed by the individual on the Child Study team who is the most familiar with the student.

Responses generated from the **Motor Concerns Questionnaire** may be helpful during the child study conference in helping to determine the appropriate professionals to be contacted.

Suggested Motor Concerns Questionnaire

Answers that fall in an asterisk * category in the following questionnaire may indicate to the team (child study conference members) that there is a need for the administrator to contact the adapted physical educator, occupational therapist, and/or physical therapist for further clarification and/or assessment. Their professional expertise will help them judge whether or not their services will be of any assistance to the child study team.

When the following questions are answered in a manner which indicates that the child's level of functioning is discrepant from his/her ability level, then such answers should be considered indicators to the Child Study Team that an adapted physical educator, occupational therapist and/or physical therapist - whichever professional seems to be the most appropriate - should become involved in the process. (Please refer to the Assessment Section for assistance).

SUGGESTED QUESTIONS TO FOCUS ON MOTOR CONCERNS

1. What is the child's age?_____ Birth Date_____ Grade Level_____

2. Does the child have a medical diagnosis? Yes**____ No _____
   If yes, what is it?_____
   Is the child/youth hearing impaired/deaf? Yes _____ No _____
   Visually impaired/blind? Yes _____ No _____

3. Has the child received motor interventions (APE/OT/PT) in the past?

   APE**___ OT**___ PT**___
   If yes, where are the reports?_____
   Duration of previous motor services? _____

4. Is the child's ability to care for him/herself significantly different from his/her age/level peers (circle which applies).* Check the appropriate categories and, if yes, describe how the task is performed:

Feeding	Yes**___	No___	NA___	How_____
Personal Hygiene	Yes**___	No___	NA___	How_____
Dressing	Yes**___	No___	NA___	How_____
Food Preparation	Yes**___	No___	NA___	How_____
Home Maintenance	Yes**___	No___	NA___	How_____
Recreational Activities	Yes**___	No___	NA___	How_____

5. Does the child effectively use school and community environments? For example, store, restaurant, playground, neighborhood?

   Yes___ No**___

6. Does the child have significant* difficulty with classroom activities such as:

attending to the task?	Yes**___	No___
writing?	Yes**___	No___
hand dominance?	Yes**___	N0___
using two hands together?	Yes**___	N0___
use/manipulation of classroom materials?	Yes**___	No___
productivity/efficiency?	Yes**___	N0___

7. Is the child clumsy? Yes**___ No___
Use an awkward gait pattern? Yes**___ No___
Use crutches? Yes**___ No___
Use a wheelchair? Yes**___ No___
Is the child's movement too slow? Yes**___ No___
Is the child's access to any environments limited due to these accessories? Yes**___ N0___ How_____

8. Does the child move safely in his/her environment? Yes___ No**___

9. Can the child find his/her way to a variety of locations within the educational environment? Yes___ No**___

10. Does the student need/use an alternate or augmentative communication system? Yes**___ No___

** If yes, describe._____

*The word "significant" used in this context should be defined by ucing the following four characteristics:

**Safe*-*the task is accomplished by the student in a safe manner.*

**Time effective/efficient*-*the task is accomplished in a manner that is both time effective and time efficient for the student with consideration given to the specific disability.*

**Independent*-*the task is done independently by the student. i f this is not possible, it is done in the most independent manner available to the student.*

**Spontaneous*-*the task is done spontaneously, or as spontaneously as possible for the individual student, if not, then the task is significantly different.*

D. REFERRAL TO SPECIAL EDUCATION

If it is the judgment of the child study team or the wish of the parent(s) or others with a vested interest in the student, a referral to special education may be made at this time. Children should not be referred unless regular education services have been unsuccessful in meeting the child's needs.

Once the student is referred to special education, parents must be informed of all their rights (procedural safeguards). This includes the right to be informed of why the student is being referred and the types of assessments that are to be conducted. Written parental permission for initial assessment is required. Once permission to test has been granted, the different assessment personnel are free to initiate the assessment process.

E. ASSESSMENT PROCESS

Definitions of the technical terms used in this section of the document are found in the appendix. Also found in the appendix are the parts of the neuromotor/developmental assessment and the functional assessment including a brief definition of each function, implications, skills necessary to assess the function and who is qualified to assess the function.

The purpose of the assessment process is to provide information to the staffing team:

1. To determine the status of a student's functional motor performance;

2. To determine the implications of the student's functional motor performance;

3. To identify the student's needs relative to his/her participation in education, home and community living;

4. To determine whether the child is handicapped; and

5. To identify the characteristics of services necessary to meet the identified needs.

A comprehensive assessment in sufficient scope and intensity is necessary to insure that appropriate intervention is incorporated into the child's program.

The motor assessment itself consists of two components:

1. The functional assessment of mobility/movement, self-care, and communication; and

2. The neuromotor/developmental assessment.

The expected outcomes of the assessment process are:

1. Determination of the student's current level of motor

functioning which includes identification of the functions demanded of the child in particular environments and the capabilities of the individual child to meet those demands;

2. Identification of the student's needs based on the assessment and the establishment of a baseline for function.

The functional assessment is an inventory of the student's independent abilities in mobility, self care and communication at school, home and the community.

The neuromotor/developmental assessment establishes the foundation components and skills required for and/or interfering with adequate movement and function. The neuromotor/developmental assessment provides the transdisciplinary team with insight into the student's capabilities. It also helps the team to determine: the foundations and causes for the functional deficits; whether or not the student can benefit educationally from interventions; and whether adapted equipment and/or adaptation of the environment will assist the student.

Ideally, the two parts of the assessment process are combined into one assessment with pertinent information obtained from other individuals such as the teacher, parent/guardian and employer if appropriate. The assessment team needs to anticipate future environments that the student may encounter.

It is recommended that students be assessed for discrepancies between their ability and functioning level, with consideration given to the environmental demands placed on them at their home, at their school and within their community (which includes the utilization of services available in the community, recreation and employment).

The choice of assessment methods is made by the adapted physical educator, occupational therapist, and/or physical therapist based on the reason for the referral as well as on the nature of the presenting problems. The assessment process involves obtaining and interpreting data. These data may be gathered through record reviews, specific observations, interviews, use of standardized tests, performance checklists and other data collection procedures.

In most instances a student with motor development problems cannot be put into specific test categories because of many variables. Most standardized tests do not allow for deviation in test administration or scoring as may be needed for a student with multiple involvements. Often inventories, checklists, and non-standardized tests are more appropriate to obtain an accurate picture of the student's performance level or physical functioning status.

If standardized tests are used on a different population than that for which they were designed and standardized, this should be noted and the emphasis placed on the response to the elicited behavior, not the earned score.

If the adapted physical educator, occupational therapist and/or physical therapist does not have adequate training to do the assessment(s) necessary and indicates this to the team leader, then his/her professional judgment should be respected. An appropriate professional should perform the assessment. Models have been provided to assist the therapist in evaluating the student (See Appendix). The adapted physical educator, occupational therapist and/or physical therapist may use these models to develop his/her own or use other commercially available models of functional and adapted behavior.

Assessment of the individual student in the physical functioning area should be done by the appropriate professional(s). The professional is urged to use his/her best judgment in assisting the school administrator to determine which is the most appropriate discipline(s) to make the assessment and to call in other disciplines as necessary to gather pertinent information. **It is each professional's responsibility to maintain current certification and/or licensure, remain updated on current techniques and philosophy, and to reflect accurately his/her professional training.**

The assessment should be accomplished by the professional with proper care taken to consider the contraindications, if any are present. If the assessor is unfamiliar with the diagnosis, then further clarification should be made to give the assessor a clear idea of how to proceed.

The process of assessment for physical movement, and functional concerns encompasses many aspects of the student. The student's basic

abilities, the student's needs in terms of functional ability, and how the student's functional abilities may be enhanced or made more useful contributes to the final outcome of the motor assessment process. Prevention of further disability or deformity may also be addressed, if they interfere with the student's ability to function. **All assessment information should be related to the student's ability to function at school, home and in the community.**

1. FUNCTIONAL COMPONENT OF THE MOTOR NEEDS ASSESSMENT:

The functional inventory may be a useful tool to the assessor to provide a comparison of the student's ability to function across different environments. Examples of functional inventories are included in the appendix of this document.

The functional assessment is intended to give an overview of the student's ability to function across different environments (school, home, community and job site) in the following areas of functioning:

1. Mobility/Movement
2. Self Management/Activities of Daily Living
3. Functional Communication/Social Interaction

The criteria used to clarify the skills/tasks are that they be accomplished in the following manner:

1. In an age/ability and appropriate manner;
2. Safely;
3. Independently (if possible);
4. In a time effective/efficient manner; and
5. Spontaneously.

2. NEUROMOTOR/DEVELOPMENTAL COMPONENT OF THE MOTOR NEEDS ASSESSMENT:

The following components of the development of functional movement patterns and their implications should be considered during the assessment process.

1. Muscle Tone
2. Strength and Endurance
3. Individual Muscle Strength
4. Joint Range of Motion
5. Joint Stability
6. Posture
7. Reflexes
8. Automatic Balance Reactions and Responses
9. Sensory Integration
10. General Gross Motor Sequence
11. Detailed Gait Analysis
12. General Fine Motor Skills
13. Visual Motor
14. Oral Motor
15. Sensation
16. Activities of Daily Living
17. Motoric Aspects of Pre-Vocational Skills

(Brief definitions of each component, educational implications, skills necessary to assess the area of function and who is qualified to provide the assessment are included in the appendix of this document.)

If discrepancies exist in environmental expectations, motor ability and function, then the adapted physical educator, occupational therapist, and/or physical therapist may be required to further participate in the staffing process and in the development of the IEP.

Some teams use the criteria of a severity rating scale following the functional and neuromotor/developmental assessments. The determination of the mild, moderate and severe ratings used in conjunction with the results from the functional and neuromotor/developmental assessments may give the staffing team a better "picture" of the student to work from in determining the type,

amount and duration of the services to be provided.

Any severity rating scale can be used in the assessment process but should never be used independent of the functional assessment and the professional's judgment.

F. STAFFING/DEVELOPMENT OF THE IEP

The staffing process involves determining the child's present level of performance, his/her needs, whether or not the child is handicapped and the characteristics of services necessary to meet his/her needs. If determined to be handicapped, the child is entitled to a free, appropriate public education. This determination can be made only by an approved staffing committee within the public school system. The Individualized Education Program (IEP) is the product of the staffing process.

Adapted physical educators, occupational therapists and/or physical therapists must be able to communicate and interact effectively as members of the assessment/staffing team. They must be familiar with and understand this process as established by both federal and state laws and regulations. The following guidelines are recommended to facilitate the staffing process:

1. TEAM COMPOSITION:

   a. The adapted physical educator, occupational therapist and/or physical therapist should be present at the staffing if he/she has a significant, direct role in the assessment process, or has had past involvement with the student, or anticipates being involved in the provision of services even if only on a consultive basis. The staffing should be scheduled to include the adapted physical educator, occupational therapist, and/or physical therapist.

   b. The adapted physical educator, occupational therapist, and/or physical therapist may not be required to attend the staffing if he/she plays an indirect role. However, all information must be presented by another team member in an understandable manner to facilitate team decision-making.

2. PRESENT LEVEL OF FUNCTIONING:

   How a student functions psychologically, physically, socially-emotionally and communicatively in the different educational

and work environments of which he/she is a part must be determined. The student's ability to function adequately and appropriately in the school, community, home, work and recreational areas must be explained. Discrepancies between the ability level and the functional level across the different environments should be noted. It is at this point that the adapted physical educator, occupational therapist and/or physical therapist must present their findings along with the findings of all other team members, including the parents, relative to how the student functions. *All team members can and should contribute information in all areas of performance. The emphasis is not on scores but rather on clear, precise summative statements that can be understood by all members of the committee, including the parent(s).* The adapted physical educator, occupational therapist and/or physical therapist should present his/her data in a clear and precise manner without the use of acronyms. Technical terminology should be used judiciously so that participants can understand what is being said. The adapted physical educator, occupational therapist and/or physical therapist should integrate his/her data with the other members of the multi/transdisciplinary team doing the assessment. Statements regarding the student's performance should be stated in such a manner that the student's strengths and weaknesses are included.

3. NEEDS:

The purpose of this section of the staffing /IEP process is to identify what needs the student has in all areas of functioning. **Some needs identified are internal to the student. These are addressed in the goal section of the IEP. Other needs are external to the student. These are addressed in the section on characteristics of services.** As a member of the team, the adapted physical educator, occupational therapist and/or physical therapist will assist the team in identifying the student's needs by providing information about functional discrepancies between the different areas and the different environments. Adequate and appropriate functioning is the end goal.

Examples of appropriately stated needs:

- The student needs to cross parking lots and/or roads safely.
- The student needs to learn to utilize playground equipment safely.
- The student needs to be able to participate and benefit from classroom activities while learning to maintain appropriate positioning.
- The student needs to be able to participate in self care activities to the maximum extent possible.
- The student needs to utilize classroom materials and supplies, e.g., paper, pencil, etc.
- The student needs specialized transportation.
- The playground needs to be made accessible for the student's use.
- The student needs bathroom assistance.
- The student will learn to self catheterize.
- The student needs to be able to participate in recreational activities appropriate to his/her abilities in a community setting.
- The student needs to develop and utilize motor skills for participation in age appropriate games.
- The student needs to develop appropriate social skills to interact with non-handicapped peers in recreational settings.

Examples of inappropriately stated needs:

- The student needs occupational and or physical therapy and/or adapted physical education.
- The student needs sensory integration therapy.
- The student needs to improve gross or fine motor activities/skills.

4. HANDICAPPING CONDITION

The staffing team is responsible for determining the primary handicapping condition which is interfering most with the student's ability to function. It is possible that the student may have other needs, which require intervention, which are not significant enough to indicate a primary handicap. It is also possible that a student may have different needs, but this does not mean that the student is multiply handicapped. It is the staffing team's responsibility to help make such determination. This determination is made by asking the following questions:

Is the child able to benefit from regular education without support from special education? Yes?_____ No?_____

If the answer is "No", does this child meet the criteria for a handicapping condition? Yes?_____ No?_____

If the answer is "Yes", what handicapping condition is it?

_____

5. ANNUAL GOALS:

The goals of the student must reflect those needs of the student that were identified at the initial and/or review staffing. If, however, the staffing team identified <u>all</u> the needs of the student, irrespective of whose obligation it was to meet those needs, then the first step must be to select out

only those needs for which the school system is responsible. Secondly, it may be impractical or perhaps impossible to attempt to meet all of the student's identified needs at the same time. For this reason, the second step requires the staffing team to prioritize the needs that are to be met. And finally, it is very possible that a number of needs may be clustered into one goal.

a. *If all student needs were identified by the staffing team, irrespective of whose obligation it was to meet those needs, the staffing team must now select those needs that must be met by the public school system. In order to do this, the following questions should be asked:*

   1. *Would the intervention be expected to contribute to the achievement of the student's overall educational goals or maintenance in the least restrictive environment?*

   2. *Has the student previously received therapy in an educational environment and/or other environments? How long ago was the service provided and what was the intensity of the service? What is the current status of the student's motor needs?*

   3. *Are the student's needs resulting from a degenerating condition or recent surgery which currently requires some degree of ongoing (direct, monitoring, consultation) intervention to maintain appropriate functioning?*

   4. *Is the student likely to regress without the intervention?*

(It is probable that in some instances the staffing team will decide that the district has no obligation to provide adapted physical education, occupational and/or physical therapy to the student. In such case, the parent/guardian may wish to pursue obtaining privately provided services

for the student at no cost to the school district. This is especially true when:

- **The student has adequate/appropriate functioning across the different environments but the parent/guardian would like a further refinement of skills*;**

- **The student's needs are not significantly impacting the student's education but the parent/guardian would like the student to benefit <u>maximally</u> from the educational process*; or**

- **The parent wishes for his/her child to benefit <u>maximally</u> from recent surgery or other medical procedures.**

***An appropriate program is one which is reasonably calculated to enable the student to progress/advance from grade to grade and/or level to level as defined on the student's I.E.P. It provides the student with the opportunity and an environment which can permit the student to benefit and progress. The staffing team has the responsibility to decide what is progress or advancement for each student.)**

An appropriate program/or appropriate functioning for the student indicates that the student is functioning within the context of the four following characteristics :

*Safe-the task is being accomplished by the student in a safe manner.

*Time effective/efficient-the task is being accomplished in a manner that is both time effective and time efficient for the student with consideration given to the specific disability.

*Independent-the task is being done independently by the student. If this is not possible, it is being done in the most independent manner available to the student.

*Spontaneous-the task is self-initiated.

(If a student was staffed as not handicapped, a referral can be made at any time in the future. If a handicapped student should later demonstrate a need for additional occupational or physical therapy, or a resumption of such services due to decreased or changed ability to function, postural asymmetries, or new concerns, an IEP review should be called.)

b. *Once the team has identified those needs that must be met by the public school system, the team may wish to prioritize and cluster the needs into one or several goals. It is important to remember that the goals are to be child centered and that only those needs that are most important for the child are to be stated as goals. After a consideration of all the needs for which the school district is responsible, the motor area may/may not be a priority related service for the student at the time of the staffing.*

When prioritizing and clustering the needs to determine which goals should be written for the I.E.P., the team should consider the following:

1. ***Is the student motivated to achieve the goals at this time? Have a variety of approaches, motivators been tried with the student?***

2. ***Does the student's behavior, cooperation and/or motivation consistently prevent motor intervention from being beneficial? Should the motor intervention be discontinued until the behavior problem is alleviated?***

3. ***Is there another staff member or parent who has better rapport with the student with whom the therapist could consult in order to***

provide some appropriate intervention?

(A delay in motor skills is not in itself enough to warrant direct motor intervention from a motor service provider. The integration of motor skills may fall into other areas of the curriculum. The motor intervention provided by those areas of the curriculum or other staff may be sufficient.)

Examples of Appropriate Goals

There are any number of ways in which to write goals depending on the age of the student, the intensity of his/her needs, etc. Students with mild/moderate needs typically learn the necessary prerequisite developmental and functional skills at school and at home. Through the process of generalization students with mild/moderate needs are able to transfer the learned skills to different environments and adapt as they grow older. For students with mild/moderate needs, especially for younger students, the school serves as a community to learn adequate and appropriate functioning.

For students with severe/profound needs, services most often are initiated in the school environment. However, the emphasis quickly shifts to teaching the student in the environments or sub-environments in which the student currently and subsequently functions since the process of generalization is less likely to occur.

Listed below are two different approaches to writing goals:

1. Goals may be stated in terms of the domains (School; Play/Leisure; Vocational; Daily Living):

    - Mary will expand her repertoire of recreational/leisure skills to include participation in 5 or more activities for 10 minutes each.

- Mary will perform three school jobs when provided adult standby assistance and verbal prompts.

- Student will utilize community facilities for recreation at least once weekly and participate in 1 of the 3 activities.

2. Goals may also be stated in terms of intensity of needs:

   - The student will successfully complete the third grade curriculum with modifications and/or adaptations.

   - The student will responsibly participate in the fourth grade with modifications and/or adaptations

   - The student will indicate a need to go to the bathroom.

Examples of Inappropriate Student Goals:

- Student will develop gross motor skills.

- Student will utilize a mature grasp during writing activities.

- Student will receive OT three times per week to improve sensorimotor abilities.

- Student will demonstrate reciprocal gait.

6. CHARACTERISTICS OF SERVICES:

Following the development of annual goals, the staffing team identifies the characteristics of services that are required to meet the identified goals: **The nature of the service; the amount of time; the staff-student ratio and the type**

of setting.

Characteristics of services are based on the needs of the student and designed to meet those needs. There are two types of student needs. Those that are identified as internal to the student. These are addressed in the development of the annual goals. The second type of need is that which is external to the student and relates to the services that is required by the student to participate in the educational environment. The second type of need is addressed in the characteristics of services.

Examples of appropriately written characteristics of services are:

- Daily round trip, home to school, transportation;
- Bathroom assistance, daily, as needed;
- Assistance with catheterization, daily, as needed;
- Individualized/integrated, 1:1 gross motor instruction to improve independent mobility, minimum of 30-60 minutes/week;
- Individualized, 1:1 fine motor instruction and gross motor instruction to improve upper and lower extremity function, minimum of 60 minutes/week;
- Individualized, 1:1 or small group adapted living instruction to improve independent dressing, at a minimum of 30-45 minutes/week;
- Small group instruction in independent mobility, a minimum of 30-45 minutes/week.
- Individualized instruction in independent mobility, a minimum of 45-90 minutes/week including instruction by other trained personnel;

- Individualized, integrated instruction in self management/activities of daily living, a minimum of 60 minutes/week;

- Individualized instruction in leisure/lifetime activities integrated within the community, a minimum of 30-60 minutes/week;

- Small group instruction for physical fitness and endurance for 30-45 minutes/week;

- Individualized consultation with the regular physical educator regarding participation in games and sports, minimum of 20 minutes/month;

- Small group instruction in play skills and developmental motor activities, a minimum of 30-60 minutes/week;

- Weekly communication between home and school;

- Individualized and group instruction within a vocational/community work site 3 times a week for one hour;

- Individualized instruction focusing on wheelchair transferring within school and community environments once a week for 30 minutes.

(A variety of therapeutic approaches have been developed by practioners. It is appropriate for the APE/OT/PT to choose the most effective combination of techniques for each student. It is inappropriate for any specific type of motor intervention technique to be used as a characteristic of service.)

7. RECOMMENDED PLACEMENT IN THE LEAST RESTRICTIVE ENVIRONMENT:

Following the identification of the characteristics of services, the student's placement in the least restrictive environment needs to be determined. The team makes the recommendation as to the appropriateness of the educational environment based on the characteristics of services necessary to meet the student's needs. Different placements are conducive to meeting different characteristics of services. Each placement should be considered, weighing what characteristics of services it is able to meet.

In accordance with the recommendation of the staffing team and with consideration given to parental wishes, the Special Education Administrator will determine the placement best suited to meet the student's needs as determined by the staffing team and in accordance with the concept of the least restrictive environment.

Alternative placement considerations which have been discussed must be noted. The amount of time the student spends in regular education and the date of the initiation of service should also be noted, with consideration given for time required to obtain the physician's prescription when required by the school district. The staffing team has 20 school days to complete the short term instructional objectives based on the goals written at the staffing.

Should the parents disagree with the placement decision, or should the district disagree with the parents' decision, avenues for appeal are available to both parties. Each school district has in place due process procedures to facilitate this appeal. A minority report may be made by any team member who disagrees with the opinion of the team.

8. DETERMINATION OF SPECIFIC SPECIAL EDUCATION INSTRUCTION AND RELATED SERVICES

Utilizing information from characteristics of services and recommended placement, the team determines the specific instructional and related services that are to be provided to the child.

9. ASSIGNMENT OF PERSONNEL TO PROVIDE SERVICES.

Within the constraints of such variables as negotiated agreements, travel and resource allocations, there is some variability in the assignment of an adapted physical educator, occupational therapist and/or physical therapist to provide identified interventions for students. Factors contributing to this variability include differences in university programs, differing areas of individual interest, past work experiences, continuing education and advanced coursework.

The administrator needs to be familiar with the basic university instruction of each profession and his/her individual specialization and expertise. The limits of overlapping skills that these professionals have should be identified and considered. The staffing team identifies the characteristics of services necessary to meet the needs of the student. The administrator must consider the professional skills required to deliver the services.

The assessment section of this guide also may provide some assistance to the administrator in determining the most appropriate service provider.

It is possible that there may be other people qualified to provide the services once a program of intervention for the student has been established. To assist the administrator the following considerations may be helpful:

a. Delineation of Professional Roles - Which Professional Do You Need?

The following questions may assist the administrator in determining which professional may best be suited to meet the student's educational needs. **An answer of "yes" to only one or a few of the questions is not necessarily an indication that these related services are to be provided by the specific discipline.** The administrator should consider the professional judgment of the adapted physical educator, occupational therapist, and/or physical therapist.

b. Indicators of a Need for the Services of a Physical Therapist:

1. Has the student previously or is he/she currently receiving physical therapy?

2. Is there a current recommendation/referral for physical therapy from a concerned party and/or a physician?

3. Does the student have a medical diagnosis indicating a need for physical therapy?

4. Does the student have difficulty with gross motor skills and/or endurance?

5. Does the student have difficulty moving through his/her environment(s)?

6. Does the student use crutches or a wheelchair as his/her primary mode of mobility?

7. Does the student have postural concerns (scoliosis, etc)?

In some instances, the administrator may wish to consult with an adapted physical educator and/or occupational therapist for additional information. It is not uncommon for a child who exhibits gross motor delays to also exhibit fine motor delays concurrently.

c. Indicators of a Need for the Services of an Occupational Therapist

1. Has the student previously or is the student currently receiving occupational therapy?

2. Is there a current recommendation/referral for occupational therapy from a concerned party?

3. Does the student have a medical diagnosis indicating a need for occupational therapy?

4. Does the student have fine/sensory/perceptual motor concerns?

5. Does the student have a decreased rate of production of "desk work" when compared to his/her peers?

6. Does the student have difficulty, when compared to his/her peers, accomplishing normal daily tasks such as dressing, personal hygiene?

7. Can the student find his/her way to a variety of locations?

8. Does the student have difficulty positioning his paper, placement of letters, numerals, etc. on the page?

9. Does the student have difficulty with problem solving?

10. Does the student have difficulty with organization of desk materials?

In some instances, the administrator may wish to consult with the adapted physical educator and/or the physical therapist for additional information. It is not uncommon for a child with developmental delays in the fine motor area to also exhibit

developmental delays in the gross motor area concurrently.

d. Indicators of a Need for the Services of an Adapted Physical Educator?

1. Does the student have a medical diagnosis indicating a need for adapted physical education?

2. Is the student safe in regular physical education?

3. Can the student appropriately participate in regular physical education?

4. What is the purpose of the student's participation in regular physical education? Is it for motor skill development, social skill development, communication development, physical fitness and endurance, or other purposes?

5. Does the student fail more often than succeed in the motor activities within any environment?

6. Is the student developing lifetime recreational/leisure activities that can be used across all environments?

7. Is the student developing skills and competencies in personal lifetime health and fitness?

In some instances, the adapted physical educator may serve as the support professional for the regular physical educator to facilitate retaining a student with a handicapping condition in regular physical education and assist the regular physical educator in remediating problems that interfere with mainstream instructions. There may be some instances when the adapted physical educator may also serve as a consultant to peer tutors, especially at the secondary level.

In some instances, the administrator may wish to consult with

a physical and/or occupational therapist for additional information. It is not uncommon for a child who would be referred for adapted physical education to also be receiving physical and/or occupational therapy.

e. When making an assignment, these two additional questions also need to be considered:

1. Can the student's needs be met by other members of the staff such as teachers, an adapted physical educator, an occupational therapist, a physical therapist, a speech therapist, another therapist in the community? Without additional specialized help will the student still be maintained in the least restrictive environment?

2. Does the student's educational instruction already provide for the necessary remediation of the handicapping condition? Examples include:

   • a speech program already includes feeding and oral-motor remediation.

   • classroom instruction covers the needed perceptual, gross motor and fine motor needs.

   • the student's physical education programming covers the needed gross motor, motor planning and perceptual needs.

10. SHORT TERM OBJECTIVES:

The short term objectives are written at the time of the staffing, annual review, or triennial review or within 20 school days following such meeting.

Examples of appropriately stated short term objectives :

- Upon arrival to school and following recess, the

when provided a verbal/gestural prompt in 8 of 10 trials.

- When presented her backpack and materials, the student will pack the materials when provided with verbal prompts 8 of 10 trials.

- During performance of daily tasks, the student will appropriately, spontaneously ask for assistance "as needed" 3 out of 4 times.

- Student will independently travel, with the use of her walker, to the bathroom, classroom and outside at least once daily.

- Student will walk, holding the hand of an adult to the bathroom, classroom or outside at least once daily.

- When presented her hairbrush and cued, "brush your hair", the student will independently brush her hair, including back and sides 8 of 10 trials.

- When presented her washcloth and cued, "Wash your face", the student will independently turn on the water and rinse the cloth, squeeze the cloth after rinsing, and wipe her face from forehead down to chin in 8 of 10 trials.

- Student will pedal and guide a bike with training wheels to a destination when provided stand-by assistance in 8 of 10 trials.

- Student will participate in a group game of jumping rope by correctly rotating through turns at twirling and jumping when provided adult supervision and verbal prompts in 8 of 10 trials.

G. ANNUAL/TRIENNIAL REVIEWS

The decision as to whether the needs of the student have changed and whether services should be continued or discontinued will depend upon the judgment as to whether the student has benefited and continues to benefit from the services; whether there has been progress; whether there will be change without the service, or whether the student continues to have other needs that were not met.

V. DELIVERY SYSTEMS

In general, there are two broad ways in which to provide services, direct and indirect. Direct services means "hands on", indirect services means through another person - professional, paraprofessional or lay person. Either system can involve a variety of methods. These systems of service delivery are not mutually exclusive, each will carry over to the other, both leading to improved function in the classroom. Some of the more commonly used methods of delivering services are:

A. Indirect Service (Consultation):

1. Collaborative:

Level 1: Individual case: Collaboration with professionals, parents or others involved with providing educational services to an individual student regarding the individual student's needs. Such student remains on the therapist's caseload.

Level 2: Colleague: Collaboration with another colleague about a student who is assigned to that motor service provider.

Collaboration can occur in the community, in integrated environments with an individual or in educational settings. Collaboration is effective within any team structure: multidisciplinary, transdisciplinary and/or interdisciplinary.

2. Monitoring:

A system designed to track the student's level of functioning . Monitoring may be done by talking to the student, the student's parents and/or teachers. Monitoring may also include and/or be accomplished by a home program, seeing the student individually, in a small group, in the classroom, in the work place, or in the community. It also refers to the act of evaluating student data collected by other members of the student's educational team.

B. Direct Service (Itinerant, Resource and Self-contained):

Direct, hands on service to the student from an adapted physical educator, occupational therapist and/or physical therapist may occur on a one on one basis, in a small group, in the classroom, in the home, school, or community. It may also occur in any type of team structure: multidisciplinary, transdisciplinary and/or inter-disciplinary.

VI. DOCUMENTATION:

Documentation is a necessary component of special education services. The motor service provider should comply with the confidentiality standards and the ethics determined by his/her administrative unit and individual professional organization. Since there is an abundance of documentation associated with the provision of special education services, the administrator should allow the motor service provider sufficient time to carry out the required documentation. Generally, the following types of documentation are expected:

1. Written summary of screening and assessments;

2. Attendance records of therapy times;

3. IEP--goals and objectives/intervention plan (written as a part of the team IEP, established at the time of the staffing, annual review, triennial review); and

4. An annual review statement of progress, which may include a discharge summary.

It is recommended, but not mandated, that the therapist keep a record of changes (positive or negative) on each student, including problems and/or concerns that arise.

VII. CASELOADS:

Caseloads may be determined by two methods:

1. Student-therapist ratio; or

2. Contact hour formula.

Examples of models for caseload determination are included in the appendix of this document. Considerations for both models should include the following:

- staffing time
- assessment time
- services to be provided
- travel time/ number of schools
- other

    number of direct interventions vs. indirect interventions

    report writing

    severity of children

APPENDIX A

CERTIFICATION STANDARDS

9.02 Occupational Therapist, K-12: To be endorsed Occupational Therapist, an applicant shall be certified as an occupational therapist, registered by the American Occupational Therapy Association, and shall have satisfactorily completed an approved occupational therapist program, in an accepted institution of higher education, designed to develop knowledge and skills in the following areas:

9.02 (1) Orientation to the role of the school occupational therapist.

9.02 (2) Scientific application of accepted therapeutic theories and practices of evaluation and treatment methods to achieve maximum function, independence, emotional, social and physical adjustment for each student served.

9.02 (3) Staffing in consultation with physicians, physical therapists, speech correctionists, nurses, social workers, psychologists, counselors, and other specialists.

9.02 (4) Community resources.

9.02 (5) Legal rights and due process of students, parents, teachers, administrators and school boards.

9.02 (6) Maintenance of records.

9.02 (7) Educational alternatives for children requiring the services of an occupational therapist.

9.02 (8) Full-time clinical affiliations in cooperating hospitals and health agencies, or field experience with handicapped children supervised by a qualified therapist.

9.02 (9) Applicants who have completed a bachelor's degree in

Occupational Therapy from an accredited institution of higher education, who are certified as an occupational therapist, registered by the American Occupational Therapy Association, and who have met certification requirements as specified in Sections 1.03(1)(a)-(c), 1.03(3), 1.04(1)-(4), 22.00(1)-(11)(c), and 23.00 of these Rules but who have not met Standards 9.02(1)-(8) above shall be eligible for a three-year Provisional I Certificate.

9.02 (10) Upon completion of three years' successful experience as a school occupational therapist, K-12, and verification by the applicant's supervisor that the applicant has demonstrated the necessary competency to serve as an occupational therapist in the Colorado public schools, and completion of certification requirements as specified in 9.02(9) above, the applicant shall be eligible, upon application, for a Type E, Special Service Certificate, endorsed K-12: Occupational Therapist.

9.02 (11) Basis and purpose. The basis and purpose of Sections 9.02, 9.02(9) and 9.02(10) of the Rules, pursuant to 22-60-113, 22-2-107, and 22-2-109, C.R.S. as amended is to add professional association certification as an endorsement requirement and to establish a procedure by which occupational therapists who have not completed course work specific to functioning in a school setting can be issued provisional certificates. Option II allows such occupational therapists, upon providing evidence of successful employment and demonstration of competency as school occupational therapists, to be granted waivers, based upon experience, of school-oriented course work and to be issued Type E Certificates endorsed K-12: Occupational Therapist. The Rule changes are necessitated by the needs of school districts to hire occupational therapists who are qualified in their professional area but who may not have completed course work as specified in State Board of Education Standards.

9.04 Physical Therapist, K-12: To be endorsed Physical Therapist, an applicant shall be licensed to practice physical therapy in the State of Colorado and shall have satisfactorily completed an approved physical therapist program in an accepted institution of higher education designed to develop knowledge and skills in the following areas:

9.04 (1) Orientation to the role of school physical therapist.

9.04 (2) Provision of physical therapy services to sensory-motor development and function.

9.04 (3) Gross and/or fine motor screening.

9.04 (4) Assessment and evaluation of referred children.

9.04 (5) Normal sensory-motor development and function.

9.04 (6) Community resources.

9.04 (7) Staffing processes and procedures.

9.04 (8) Interpretation of medical reports and prescriptions and appropriate compliance.

9.04 9) Educational alternatives for sensory-motor handicapped children.

9.04 (10) Legal rights and due process of students, parents, teachers, administrators and school boards.

9.04 (11) Maintenance of records.

9.04 (12) Consultation with teachers and other professional groups and parents.

9.04 (13) Treatment of sensory-motor problems.

9.04 (14) Supervised practicum in a school setting, or two years of field experience with sensory-motor impaired children supervised by a qualified, registered physical therapist.

9.04 (15) Applicants who have completed a bachelor's degree in Physical Therapy from an accredited institution of higher education, who are licensed to practice in the State of Colorado and have met certification requirements as specified in Sections 1.03(1)(a)-(c), 1.03(3), 1.04(1)-(4), 22.00(1)-(11)(c), and 23.00 of these Rules but have not met Standards 9.04 (1)-(14) above shall be eligible for a three-year Provisional I Certificate.

9.04 (16) Upon completion of three years' successful experience as a school physical therapist, K-12, and verification by the applicant's supervisor that the applicant has demonstrated the necessary competency to serve as a physical therapist in the Colorado public schools and completion of certification requirements as specified in 9.04 (15) above, the applicant shall be eligible, upon application, for a Type E, Special Service Certificate, endorsed K-12: Physical Therapist.

9.04 (17) Basis and purpose. The basis and purpose of Sections 9.04, 9.04(15) and 9.04(16) of the Rules, pursuant to 22-60-113, 22-2-107, and 22-2-109, C.R.S., as amended is to add licensure as an endorsement requirement and to establish a procedure by which physical therapists who have not completed course work specific to functioning in a school setting can be issued provisional certificates. Option II allows such physical therapists, upon providing evidence of successful employment and demonstration of competency as school physical therapists, to be granted waivers and to be issued Type E Certificates endorsed K-12: Physical Therapist. The Rule changes necessitated by the needs of school districts to hire physical therapists who are qualified in their professional area but who may not have completed course work as specified in State Board of Education Standards

APPENDIX B

ASSESSMENT

FUNCTIONAL COMPONENT OF THE MOTOR NEEDS ASSESSMENT

Ideally, this is not a separate component of the assessment but inclusive with the other components of the development of movement. The functional inventory may be a useful tool to the assessor to provide a comparison of the student's ability to function across different environments. Examples of functional inventories are included in the appendix of this document.

The functional assessment is intended to give an overview of the student's ability to function across different environments (school, home and the community, including utilization of available services, recreation, and employment) in the following areas of functioning:

- Mobility/Movement
- Self Management/Activities of Daily Living
- Functional Communication/Social Interaction

The criteria used to clarify the skills/tasks are that they be accomplished in the following manner:

- In an age/ability and appropriate manner;
- Safely;
- Independently (if possible);
- In a time effective/efficient manner; and
- Spontaneously.

WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT

Ideally, the assessor for the functional assessment would be the same individual(s) who performed the neuromotor/developmental assessment. Care should be taken by the assessor(s) not to generalize the student's

performance across the different environments. In many cases the student may not generalize his functional skills from one environment to another.

In order for the assessor to easily gain knowledge of how the student functions within his/her present environments the assessor may logically seek information from others, provided that others use the same methods/basis for determining the student's functional level, e.g., Never=0; Sometimes=1-2/5; Frequently=3-4/5; Always=5/5.

Other logical participants may include:

- parent/guardian
- teachers
- aides
- physical therapists
- occupational therapists
- adapted/regular physical educators
- employer

The following may be used as guidelines to provide the assessor and/or other participants making the assessment with some clarification.

A. MOBILITY/MOVEMENT:

Methods used to move through the environment. The primary pattern should be age appropriate, provide safety, comfort, security, with good positioning and should be energy and time efficient. It may include: rolling, crawling, walking, using a wheelchair (manual or electric), using a trike or use of assistive/or Adapted equipment (walkers or braces) which enhance mobility.

1. IMPLICATIONS:

Problems with mobility interfere with the student's ability to move through the environment in a safe, energy efficient and time expedient manner. It may also interfere with the student's spatial awareness and body awareness since these are developed through mobility.

2. SKILLS NECESSARY TO ASSESS THIS AREA:

a. The ability to observe mobility/movement;

b. The ability to correlate/integrate the results found during the neuromotor/developmental assessment with the results of the functional assessment.

c. The ability to document on a checklist or other tool;

d. The ability to document descriptive terms which help define the area of concern e.g. the child is weak; the movement is difficult; the child struggled to complete the task; and

e. The ability to assess and integrate the current and anticipated environmental demands.

B. SELF MANAGEMENT/ACTIVITIES OF DAILY LIVING:

The student's use of movement, positioning, muscle tone, balance, gross and fine motor skills to produce functional skills such as independent eating, mobility, transfers to and from wheelchairs, independent dressing and bathrooming and/or personal hygiene. Independent living may also be explored and taught.

1. IMPLICATIONS:

Problems with activities of daily living affect the student's feelings of self worth and confidence. The achieved level of independent daily living activities relates to the level of independent, adult functioning the student will achieve.

2. SKILLS NECESSARY TO ASSESS THIS AREA:

a. The ability to observe self, management/activities of daily living.

b. The ability to correlate the results found during the neuromotor/developmental assessment with the results

of the functional assessment.

c. The ability to document on a checklist or other tool.

d. The ability to document descriptive terms which help define the area of concern e.g. the child is weak; the movement is difficult; the child struggled to complete the task.

e. The ability to assess and integrate the current and anticipated environmental demands.

C. FUNCTIONAL COMMUNICATION/SOCIAL INTERACTION:

Ability of the child to functionally understand and use language: may include verbal, alternative and augmentative communication systems. These may be affected by: positioning, movement experience, pointing, range of motion, head and/or eye control.

1. IMPLICATIONS:

Problems in functional communication may interfere with the student's ability to make even their most basic of needs known to others. Other problems may include the provision of and placement of augmentative communication devices and/or switches.

2. SKILLS NECESSARY TO ASSESS THIS AREA:

a. The ability to observe functional communication/social interaction;

b. The ability to correlate the results found during the neuromotor/developmental assessment with the results of the functional assessment;

c. The ability to document on a checklist or other tool;

d. The ability to document descriptive terms which help define the area of concern e.g. the child is weak; the

movement is difficult; the child struggled to complete the task; and

e. The ability to assess and integrate the current and anticipated environmental demands.

NEUROMOTOR/DEVELOPMENTAL ASSESSMENT

A. MUSCLE TONE:

The readiness state of the muscle to respond to provide movement or stability. It may be high, low, normal or fluctuating. It provides the body the ability to move and assume or change positions against gravity.

1. IMPLICATIONS:

Problems with muscle tone (abnormal muscle tone) may be seen in the child's inability to gain stability, inability to control movements, or move freely. Abnormal muscle tone contributes to:

a. discomfort and difficulty in concentration, and

b. formation of deformities necessitating surgery and contributing to discomfort and poor posture, functional control of arms, head, trunk, legs, etc.

2. SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:

a. Training in the ability to differentiate between low, normal, high and fluctuating muscle tone;

b. Understanding of how this impacts on movement and posture and attention span or physical fatigue;

c. Current experience and knowledge of normal and abnormal muscle tone; and

d. Understanding of how muscle tone affects the student across the different environments.

3. WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:

OCCUPATIONAL THERAPISTS
PHYSICAL THERAPISTS

B. STRENGTH AND ENDURANCE:

Provide the student with the ability to safely and efficiently perform a task or move without tiring.

1. IMPLICATIONS:

Problems with strength and endurance interfere with the student's ability to perform at the same level as his/her peers in the gross or fine motor areas. Handwriting may be slow and inefficient; walking may not allow the student to move the distances required in the school or may be too slow to be time and energy expedient. Fatigue may be a factor interfering in the student's performance and attendance at school.

2. SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:

a. Knowledge of normal levels of strength and endurance;

b. The ability to differentiate between normal and below normal functioning;

c. An understanding of the effect of decreased endurance and strength on movement, posture and function; and the interrelationship between movement, posture and function;

d. An understanding of the strength and endurance required to perform specific activities, especially those associated with functional level in the educational setting; and

e. An understanding of how strength and endurance may affect the student in the different environments.

3. WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:

ADAPTED PHYSICAL EDUCATORS
OCCUPATIONAL AND PHYSICAL THERAPISTS

C. INDIVIDUAL MUSCLE STRENGTH:

The ability of an individual muscle to move in isolation against gravity and to take resistance.

1. IMPLICATIONS:

Problems may interfere with the ability to execute functional movement, may cause deformities.

2. SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:

a. An ability to test individual muscles;

b. A knowledge and understanding of normal muscle strength; and

c. An understanding of the impact of the muscle imbalance on the student's ability to function across the different environments.

3. WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:

PHYSICAL THERAPISTS
OCCUPATIONAL THERAPISTS

D. JOINT RANGE OF MOTION:

The amount of normal movement in a joint.

1. IMPLICATIONS:

Problems with joint range of motion contribute to decreased function (the inability to reach for objects or to sit in a chair with comfort and stability.) Decreased joint range of motion may also contribute to deformities.

2. SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:

a. Knowledge of normal joint range of motion;

b. Knowledge of impact of abnormal ranges of motion of movement, positioning, posture and function and the development of deformities;

c. Knowledge of normal range of flexibility;

d. Ability to measure the joint range of motion of individual joints; and

e. How the lack of normal range of motion affects the student across the different environments.

3. WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:

PHYSICAL THERAPISTS
OCCUPATIONAL THERAPISTS
ADAPTED PHYSICAL EDUCATORS (assess functional range of motion in terms of flexibility and function but do not measure individual joints or provide implications for deformity)

E. JOINT STABILITY: (Joint Cocontraction)

The ability to maintain a stable foundation from which to function: the ability to superimpose mobility on stability and/or stability on mobility.

1. IMPLICATIONS:

Problems with joint stability are not limited to but may be reflected in poor balance, poor head control, poor pencil control.

2. SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:

a. Ability to analyze movement and recognize joint instability;

b. Ability to recognize the impact of joint instability on function;

c. Ability to recognize the impact of joint instability on deformities relative to different diagnosis; and

d. Impact of joint instability on a student across different environments.

3. WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:

PHYSICAL THERAPISTS
OCCUPATIONAL THERAPISTS

F. POSTURE:

The upright positioning of the body on the skeletal frame, i.e. the absence of scoliosis, kyphosis or lordosis. Good posture contributes to better functional use of head, trunk, and arms in the classroom, community, work and recreational environments.

1. IMPLICATIONS:

Posture problems may contribute to health problems (decreased cardiovascular function, pulmonary function, and/or digestive function). The limitations imposed by postural problems may limit the participation of the student in recreational, academic or vocational activities.

2. SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:

a. A knowledge of the components of normal posture;

b. A knowledge of the components of abnormal posture (e.g. scoliosis, kyphosis, lordosis, leg length discrepancies); and

c. A knowledge and understanding of the impact of deformities with relation to different diagnosis and etiologies.

3. WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:

PHYSICAL THERAPISTS
ADAPTED PHYSICAL EDUCATORS (dependent upon their training and experience)
NURSES (dependent upon their training and experience)
PHYSICAL EDUCATORS (qualified as related to physical education and sports)

G. REFLEXES:

A movement response to a stimulus that is nearly always the same and not under the student's voluntary control.

1. IMPLICATIONS:

Problems with reflex activity may be complex because they are involuntary and dependent upon the strength of the stimulus and the position of the student's head and body. Abnormal reflex activity may ability to control his head, the student's ability to grasp, the student's safety and positioning. The student's ability to attend to the classroom or other activity may also be interrupted.

2. SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:

a. The ability to assess apedal, quadrupedal, bipedal reflexes as postulated by standard texts;

b. A knowledge of the normal reflex development;

c. A knowledge of the normal developmental sequence; and

d. A knowledge and understanding of the impact of abnormal reflex development on the acquisition of deformities, postural and positioning concerns, and on movement and function.

3. WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:

PHYSICAL THERAPISTS
OCCUPATIONAL THERAPISTS
ADAPTED PHYSICAL EDUCATORS (dependent upon their training and experience)

H. AUTOMATIC BALANCE REACTIONS AND RESPONSES:

Provide the child with the ability to maintain and/or regain an upright body position.

1. IMPLICATIONS:

Problems with the automatic balance reactions and responses may interfere with the student's ability to safely sit or move in the environment without adaptation.

2. SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:

a. A knowledge of normal equilibrium, righting and protective reflex development;

b. A knowledge of the normal developmental sequence;

c. The knowledge and understanding of the impact of the abnormal reflex development patterns;

d. The knowledge and understanding of the impact of lack of automatic reactions on function;

e. A knowledge of joint stability; and

f. A knowledge of weight shift.

3. WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:

PHYSICAL THERAPISTS
OCCUPATIONAL THERAPISTS
ADAPTED PHYSICAL EDUCATORS (dependent upon their training and experience)

I. SENSORY INTEGRATION (S-I):

The organization of sensory information into a functional output. It is necessary for adapted responses, learning a new task, internal organization, spatial and/or body awareness, or a coordinated movement.

1. IMPLICATIONS:

Problems with sensory integration interfere with the student's ability to interpret and respond according to the sensory cues (visual, auditory, tactile, kinesthetic and proprioceptive) being provided by the environment. This interferes with the student's ability to adapt and/or inhibit the unnecessary information coming into the central nervous system from the environment, which may interfere with the ability to learn and process new information. It may interfere with the student's ability to adapt to the environment in a reliable manner.

2. SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:

a. A knowledge and understanding of normal sensory-motor developmental sequence;

b. A knowledge and understanding of S-I theory; and

c. A knowledge and understanding of how a lack of sensory integration impacts function across the different environments.

3. WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:

OCCUPATIONAL THERAPISTS
PHYSICAL THERAPISTS (dependent upon their training and experience)
PC/EH TEACHERS (may provide intervention in the classroom)
ADAPTED PHYSICAL EDUCATORS (dependent upon their training and experience)

J. GENERAL GROSS MOTOR SEQUENCE:

The process the student moves through to attain an upright position against gravity and the ability to walk. Includes the basic movement patterns and combinations of movements to be independent in gross motor skills.

1. IMPLICATIONS:

Problems in this area prohibit the child from developing a flexible repertoire of movement patterns and the attainment of complex motor skills.

2. SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:

a. A knowledge of normal motor development;

b. A knowledge of normal movement patterns;

c. A knowledge and understanding of abnormal movement patterns; and

d. A knowledge and understanding of impact of both the normal and the abnormal movement patterns on the student's ability to function within the different environments.

3. WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:

PHYSICAL THERAPISTS
OCCUPATIONAL THERAPISTS
ADAPTED PHYSICAL EDUCATORS (dependent upon their training and experience)
PHYSICAL EDUCATORS (dependent upon their training and experience)
EDUCATORS/SPECIAL EDUCATORS (dependent upon their training and experience)

K. DETAILED GAIT ANALYSIS:

A comprehensive analysis or the normal/abnormal parts of the student's ability to walk.

1. **IMPLICATIONS:**

   Problems with walking interferes with the student's ability to move through the environment. Problems with walking may interfere with the student's ability to be safe in the environments and environmental conditions in which he/she functions as well as to maintain stable standing balance.

2. **SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:**

   a. A knowledge of normal motor development;

   b. A knowledge of normal movement patterns required for walking;

   c. A knowledge of abnormal movement patterns;

   d. A knowledge and understanding of impact of both the normal and the abnormal movement patterns on the child's ability to function within the different environments; and

   e. A knowledge of bracing, orthotics and other adaptive equipment which may be utilized to improve/facilitate the student's performance.

3. **WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:**

   PHYSICAL THERAPISTS

L. GENERAL FINE MOTOR SKILLS:

A comprehensive term usually used to identify combinations of hand and finger movements but also includes the ability to pick up, put down, and position objects in the hand for use.

1. IMPLICATIONS:

Problems in this area affect manipulation of classroom objects, penmanship, reading and activities of daily living, the use of tools appropriate to the situation (such as the elementary classroom, high school labs, and the workplace). The problem would be reflected in clumsiness and increased time to accomplish the task.

2. SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:

a. A knowledge of normal developmental sequence;

b. A knowledge of normal movement patterns and positioning;

c. A knowledge and understanding of impact of impaired fine motor skills on the student's ability to function;

d. A knowledge of joint stability; and

e. A knowledge of the development of grasp patterns.

3. WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:

OCCUPATIONAL THERAPIST
PHYSICAL THERAPIST (dependent upon their training and experience)
ADAPTED PHYSICAL EDUCATORS (dependent upon their training and experience)
SPECIAL EDUCATION TEACHERS (dependent upon the severity of the child's problems, the training and experience of the professional)

M. VISUAL MOTOR:

The development of smooth, coordinated eye movements from side to side, across midline vertically and diagonally. Includes convergence and divergence. Does not include acuity.

1. IMPLICATIONS:

Problems in this area are associated with difficulty with eye tracking. The inability to track objects, letters, etc. with the eyes interferes with many of the other areas of functioning.

2. SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:

a. The ability to identify normal movement patterns;

b. A knowledge and understanding of the sequential development of eye control;

c. An understanding of the impact of abnormal eye movement patterns on function; and

d. A knowledge and understanding' of abnormal eye movement patterns.

3. WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:

OCCUPATIONAL THERAPIST
VISION SPECIALISTS
PHYSICAL THERAPIST (dependent upon their training and experience)
ADAPTED PHYSICAL EDUCATORS (dependent upon their training and experience)
TEACHERS (dependent upon their training and experience)
NURSES (dependent upon their training and experience)

N. Oral Motor:

A close inspection of the child's lip closure, tongue movement, swallowing abilities, sound production.

1. IMPLICATIONS:

Problems in this area may interfere with the student's ability to swallow saliva, making the student socially unacceptable. It may also interfere with eating and with the student's speech.

2. SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:

a. A knowledge of normal developmental sequence;

b. A knowledge of abnormal movement components;

c. A knowledge of abnormal reflexes/reflex patterns;

d. An understanding of normal oral motor function; and

e. A knowledge and understanding of the impact of abnormal oral motor functioning on the student's ability to function across the different environments.

3. WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:

SPEECH AND LANGUAGE SPECIALIST (dependent upon their training and experience)
OCCUPATIONAL THERAPIST (dependent upon their training and experience)
PHYSICAL THERAPIST (dependent upon their training and experience

O. SENSATION:

A detailed inspection of the child's tactile sensory levels to hot/cold, light touch, sharp/dull pain, etc.

1. IMPLICATIONS:

Problems with this area may interfere with the student's ability to have knowledge of hot/cold temperatures, making them more susceptible to burns and frostbite. It interferes with their ability to feel pain in a specific area (dermatome). It may interfere with their ability to maintain and regulate body temperature. One of the major concerns is the student's ability to keep himself safe in all situations.

2. SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:

a. An understanding of the body's tactile system;

b. The ability to assess for sensory loss in the tactile area: hot/cold, sharp/dull, kinesthesia; and

c. A knowledge and understanding of the impact of a lack of sensation on how the student will function across the different environments.

3. WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:

PHYSICAL THERAPISTS
OCCUPATIONAL THERAPISTS (for upper extremity sensation)

P. ACTIVITIES OF DAILY LIVING:

A detailed inspection of the student's ability to perform age/ability and appropriate functional daily living skills with or without adaptation.

1. IMPLICATIONS:

Problems in this area may limit the student's ability to function within the different environments.

2. SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:

a. Knowledge and understanding of normal development;

b. Knowledge and understanding of normal/abnormal motor patterns; and

c. Knowledge and understanding of adapted techniques and equipment to facilitate performance of activities of daily living.

3. WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:

OCCUPATIONAL THERAPISTS
PHYSICAL THERAPISTS (dependent upon their training and experience)
SPECIAL EDUCATION TEACHERS (dependent upon their training and experience)

Q. MOTOR ASPECTS OF WORK RELATED SKILLS:

A detailed inspection of the student's work status-sitting, standing, endurance, reaching, fine motor and manipulative skills, visual motor control, etc. This information may be gathered from the previous sections of the assessment and included in the functional assessment. Data gathering should include visitation to work-place and/or job site to determine accessibility, environmental and equipment adaptations, etc.

1. IMPLICATIONS:

Problems in this area may include inappropriate job site selection and inappropriate work expectations.

2. SKILLS NECESSARY TO ASSESS THIS AREA OF FUNCTION:

a. Knowledge of normal patterns of movement;

b. Knowledge of stability;

c. Knowledge of environmental factors which could prohibit or interfere with the student's ability to perform on the job site or perform the specific job task

d. Knowledge of accessibility;

e. Knowledge and understanding of the impact of abnormal eye movement patterns on function;

f. The ability to make an analysis of reach, grasp, release and manipulative patterns;

g. A knowledge and understanding of the impact of the lack of automatic balance reactions on function;

h. A knowledge and understanding of the components of posture and the impact of poor posture on the student (decreased performance and deformities);

i. A knowledge of adapted techniques and equipment to facilitate/improve performance; and

j. A knowledge of appropriate communication skills as related to the social and functional aspect of the work place.

3. WHO IS QUALIFIED TO PROVIDE THIS TYPE OF ASSESSMENT:

OCCUPATIONAL THERAPISTS
PHYSICAL THERAPISTS (dependent upon their training and experience)
VOCATIONAL TEACHERS (dependent upon their training and experience)
SPECIAL EDUCATORS (dependent upon their training and experience)

APPENDIX C

SEVERITY RATING SCALES

SEVERITY SCALE - DRAFT

JEFFERSON COUNTY PUBLIC SCHOOLS

DEVELOPMENTAL & ADAPTED PHYSICAL EDUCATION
OCCUPATIONAL THERAPY/PHYSICAL THERAPY

Purpose of Severity Scale:

To determine level of service

To provide guidelines for determining frequency of services

To provide ongoing assessment of benefit of service

To monitor progress

To provide information to school personnel and parents on severity and need of services

To examine termination of services

The use of the Severity Scale to assist in district wide planning of the Itinerant Motor Services:

To identify and manage caseloads

To establish consistency in service criteria

To assist in overall program implementation and evaluations

To provide a service continuum based on needs

TABLE 1

CATEGORIES FOR DETERMINING A SEVERITY RATING AND DAPE/OT/PT SERVICE DELIVERY MODE

	POINT EQUIVALENCY
CATEGORY A: AGE OF CHILD	
Level 1 - Kindergarten-1st grade	3
Level 2 - 2nd-3rd grade	2
Level 3 - 4th grade	1
Level 4 - 5th-6th grade	0
CATEGORY B: AMOUNT OF DEVELOPMENTAL DELAY AFFECTING CLASSROOM PERFORMANCE	
Level 1 - 24 mo. or more delay	3
Level 2 - 12 mo.-23 mo. delay	2
Level 3 - Delay is commensurate with developmental delay in other areas (determined after 2nd grade)	1
Level 4 - 0-11 mo. delay	0
CATEGORY C: BENEFIT OF PREVIOUS MOTOR INTERVENTIONS	
Level 1 - Making progress or continues to raise scores to goal level and is still in need of service OR IEP not written due to just being assessed	3
Level 2 - Average progress on goals and objectives but good potential to improve	2
Level 3 - No progress on achieving goals and objectives due to handicapping condition, developmental level or behavior	1
Level 4 - Achieving goals and objectives on IEP and no longer needs service OR help now given by classroom/PE teacher	0
CATEGORY D: AMOUNT OF PREVIOUS MOTOR SERVICES AT THE ELEMENTARY LEVEL	
Level 1 - 0-9 school months without any time gaps (0-1 sch. yr.)	3
Level 2 - 10-18 school months without any time gaps (1-2 sch. yr.)	2
Level 3 - 19-27 school months without any time gaps (2-3 sch. yr.)	1
Level 4- 28 or more school months without any time gaps (3 or more sch. yr)	0

TABLE 2

SEVERITY RATING SCALE AND DAPE/OT/PT
SERVICE DELIVERY MODE

TOTAL POINTS	SEVERITY RATING SCALE	DAPE/OT SERVICE DELIVERY MODE
11-12 pts	High Priority	A. Direct Service by DAPE/OT/PT Specialist 30-60 min per wk 1) Small group 2) Individual 3) Small group and/or individual
9-10 pts	Moderate Priority	B. Direct Service by DAPE/OT/PT Specialist 20-30 min 2-4x/month OR Direct Service by DAPE/OT/PT Specialist 20-30 min 1 2x/month AND Consultation with teacher/aide 10-20 min 1-2x/month (May have specific classroom program)
7-8 pts	Low Priority	C. Direct Service by DAPE/OT/PT Specialist 10-20 min 1x/month OR Consultation with teacher/aide 10-20 min total time 1-2x/month (May or may not have specific classroom program)
0-6 pts	Termination or Not a Priority	D No DAPE/OT/PT direct or consultative services OR Monitor 1x/year or as needed by DAPE/OT/PT Specialist

CRITERIA FOR DETERMINING D.A.P.E./THERAPY SERVICES

March 5, 1986

A student will be considered for DAPE/Therapy Services based upon his or her educational needs according to the following factors. No one factor will be considered in isolation; however, at times one or more factors may be of greater significance than others.

HIGH PRIORITY

1. Youngest of served population
2. Indication on IEP of motor services from SERS, Fletcher Miller, Pre-school or other school districts
3. Potential for increased function
4. Already Educationally Handicapped or to be determined through a scheduled staffing
5. Greatest delay in fine and gross motor skills and sensory motor that affect classroom performance
6. Shown direct benefit from DAPE/therapy intervention

MODERATE PRIORITY

1. Youngest of served population
2. Shown some benefit from DAPE/therapy intervention
3. Some delay in motor skills affecting classroom performance

LOW PRIORITY

1. Older children who have plateaued either developmentally or functionally or reached appropriate motor level
2. These who have received several years of previous DAPE/therapy services
3. Shown minimal or no benefit from DAPE/therapy intervention
4. Delay in motor skills is commensurate with developmental delay in cognition, speech/language, etc.
5. Shows minimal or no delay in motor skills affecting classroom performance
6. Recovered from illness or injury and no longer interfering with educational performance

CRITERIA FOR TERMINATION OF MOTOR SERVICES OR NO SERVICES

1. Older child who has plateaued developmentally or functionally
2. Reached appropriate developmental level
3. Received several years DAPE/therapy with minimal or no benefit from intervention
4. Delay in motor skills is commensurate with developmental delay in cognition, speech/language, etc.
5. Functioning within average range on formal testing

Procedures for the Record Sheet:

Beginning of the Year:

1. Rate all students currently enrolled in DAPE/OT/PT.

2. Rate all students following assessment new to the district and add to the Record sheet.

Ongoing:

1. Add each student referred, assessed and new to services.

2. Add closing date and severity rating for each terminated student.

3. Send a copy monthly after tabulation to the DAPE/OT/PT supervisor.

End of the Year:

1. Complete end of year data.

2. Add names of students coming from preschool or pending from referrals for fall.

3. Send a copy to the DAPE/OT/PT supervisor.

RECORD SHEET FOR DAPE/OT

Specialist: Name: Area:

Information							BEGINNING OF YEAR DATA								END OF YEAR DATA AND STATUS											
						Rating			Type of Services (3 one)				Rating				Type of Services (3 one)				*Check ONLY one					
Name:	Age	Start Date	Year of DAPE/OT	Previous Service	Handicap	Total Points	Severity Rating	Service Delivery	A. High Priority	B. Mod. Priority	C. Low Priority	D. Term. or Not	Total Points	Severity Rating	Service Delivery	A. High Priority	B. Mod. Priority	C. Low Priority	D. Term. or Not	Terminate Service	Continue Current	Delivery	Change Delivery	Moved out of District Continue Services New School	Identify Name of New School within District	
TOTALS																									Total load this yr.	

For Monthly Report

For End of Year Data

Sample Statements for Reports and IEP:

Case Reports:

"According to the Jefferson County DAPE/OT/PT severity rating, this student rates _____ which indicates a _____ service delivery mode."

Case Staffing-IEP:

(1016 Record under Assessment Summary)
(1020 Annual Review, record under Assessment/Observation)

"The DAPE/OT/PT severity rating of _____ indicates this student should receive _____ services.."

Goals and Objectives - IEP:

(1019 Record under Baseline)

"Severity Rating _____."

Note: Methods/Strategies should reflect service delivery mode.

EXAMPLES

1. Susie Sled is a second grader with one year motor delay; she has no IEP and no previous service.

Category A	Level	2	Point Equivalent	2
Category B	Level	2	Point Equivalent	2
Category C	Level	1	Point Equivalent	3
Category D	Level	1	Point Equivalent	3
			Total Points	10

Severity Rating [moderate priority] Service Delivery Mode [B-2]

Description: Direct Service 1-2 times per month plus an aide 1-2 times per month or a classroom program.

2. Mark Swing is a fifth grader with a 25 month delay, who has an IEP that he was partially achieving, and has had over 2 years of DAPE/OT service

Category A	Level	2	Point Equivalent	2
Category B	Level	2	Point Equivalent	2
Category C	Level	1	Point Equivalent	3
Category D	Level	1	Point Equivalent	3
			Total Points	10

Severity Rating [not a priority] Service Delivery Mode [D-2]

Description: monitor one time a year or as needed

MODIFICATION OF JEFF. CO R-1 SEVERITY RATING SCALE FOR OT/PT/DAPE

STEP 1

In order to determine the type of service to be provided for a child and a severity rating refer to TABLE 1 and follow the formula below.

FORMULA

A child should be scored in each of the four categories (A-D). Choose only one level for each of the four categories and note it below. Then find the point equivalency for each level and record below. Add the total points and record below in the box.

CATEGORY A	LEVEL _____	POINT EQUIVALENCY _____
CATEGORY B	LEVEL _____	POINT EQUIVALENCY _____
CATEGORY C	LEVEL _____	POINT EQUIVALENCY _____
CATEGORY D	LEVEL _____	POINT EQUIVALENCY _____
CATEGORY E	LEVEL _____	POINT EQUIVALENCY _____

TOTAL POINTS _____

STEP 2

Take the Total Point score above and refer to TABLE 2 to determine corresponding Severity Rating. Record below:

SEVERITY RATING _____

STEP 3.

Take the Severity Rating and refer to TABLE 2 to determine the corresponding delivery mode. Record the letter and number in the box below and write out the description below:

SERVICE DELIVERY MODE _____ DESCRIPTION _____

STEP 4

Record the total points, severity rating, service delivery mode on the RECORD SHEET.

TABLE 1

CATEGORIES FOR DETERMINING A SEVERITY RATING
AND OT/PT/DAPE DELIVERY MODE

CATEGORY A: AGE OF CHILD

LEVEL 1:	INFANT/PRESCHOOL	3
LEVEL 2:	KINDERGARTEN/1ST GRADE	3
LEVEL 3:	2ND/3RD GRADE	2
LEVEL 4:	4TH GRADE	1
LEVEL 5:	5TH/6TH GRADE	0

CATEGORY B: AMOUNT OF MOTOR DELAY CONTRASTED TO OVERALL DEVELOPMENTAL DELAY

LEVEL 1:	24 MONTH OR MORE DELAY	3
LEVEL 2:	12-23 MONTH DELAY	2
LEVEL 3:	DELAY IS COMMENSURATE WITH DEVELOPMENTAL DELAY IN OTHER AREAS (DETERMINED AFTER 2ND GRADE)	1
LEVEL 4:	0-11 MONTH DELAY	0

CATEGORY C: BENEFIT OF PREVIOUS MOTOR INTERVENTIONS

LEVEL 1:	ACHIEVING GOALS AND OBJECTIVES ON IEP OR IEP NOT WRITTEN DUE TO RECENT ASSESSMENT	3
LEVEL 2:	PARTIALLY ACHIEVING GOALS AND OBJECTIVES ON IEP (PROGRESSING)	2
LEVEL 3:	PARTIALLY ACHIEVING SOME GOALS AND OBJECTIVES ON IEP, WITH SOME NOT ACHIEVED OR NOT TAUGHT	1
LEVEL 4:	IEP NOT NEEDED OR MOTOR HELP NOW PROVIDED BY CLASSROOM OR PE TEACHER	0

CATEGORY D: AMOUNT OF PREVIOUS MOTOR INTERVENTION AT THE ELEMENTARY LEVEL

LEVEL 1:	0-9 SCHOOL MONTHS WITHOUT ANY TIME GAPS (0-1 SCHOOL YEAR)	3
LEVEL 2:	10-18 SCHOOL MONTHS WITHOUT ANY TIME GAPS (1+-2 SCHOOL YEARS)	2
LEVEL 3:	19-27 SCHOOL MONTHS WITHOUT ANY TIME GAPS (2+-3 SCHOOL YEARS)	1
LEVEL 4:	28 OR MORE SCHOOL MONTHS WITHOUT ANY TIME GAPS (3+ OR MORE SCHOOL YEARS)	0

CATEGORY E: RECENTNESS OF INJURY/DISABILITY

THIS LEVEL PRIMARILY RELATES TO HEAD AND/OR SPINAL CORD INJURED:

LEVEL 1:	NEW HEAD INJURY (LESS THAN 15 MONTHS POST TRAUMA)	3
LEVEL 2:	RECENT HEAD INJURY (16-24 MONTHS POST TRAUMA)	2
LEVEL 3:	25-36 MONTHS POST TRAUMA	1
LEVEL 4:	GREATER THAN 37 MONTHS POST TRAUMA	0

TABLE 2

SEVERITY RATING SCALE AND SERVICE DELIVERY MODE

TOTAL POINTS	SEVERITY RATING	SERVICE DELIVERY MODE
11-15 POINTS	HIGH	A. DIRECT SERVICE 30-60 MIN/WEEK 1. INDIVIDUAL AND/OR 2. SMALL GROUP
9-10 POINTS	MODERATE	B. 1. DIRECT SERVICE 20-30 MIN/WEEK 2-4X/MONTH OR 2. DIRECT SERVICE 20-30 MIN/WEEK WITH CONSULTATION TO TEACHER AND/OR AIDE
7-8 POINTS	LOW	C. 1. DIRECT SERVICE 10-20 MIN/MONTH OR 2. CONSULTATION WITH TEACHER AND/OR AIDE 10-20 MIN, 1-2X MONTH
0 - 6	TERMINATION/ NOT A PRIORITY	D. NO DIRECT OR CONSULTATION. MAY MONITOR 1-2X PER YEAR.

APPENDIX D

EXAMPLES OF FUNCTIONAL CHECKLISTS
AND
A BASIC FUNCTIONAL CURRICULUM

HOUSEHOLD ACTIVITIES PERFORMANCE TEST

NAME: _____ DATE: _____

SITTING POSITION: Chair_____ Stool_____ Wheelchair_____
STANDING POSITION: Braces_____ Crutches_____ Canes_____
HANDEDNESS: Dominant Hand_____ One Hand Only_____
Assistive_____

KEY
I = Independence
ND = Needs Direction
PH = Physical Help
N = Cannot Do

CLEANING ACTIVITIES:	PARENT OBSERVATIONS	COMMENTS
1. Pick up objects from floor		
2. Wipe up spills		
3. Make bed (daily)		
4. Change sheets on bed		
5. Use dust mop		
6. Shake dust mop		
7. Dust high surfaces		
8. Dust low surfaces		
9. Wash kitchen floor		
10. Sweep with broom		
11. Use dust pan		
12. Use vacuum cleaner		
13. Use vacuum cleaner attachments		
14. Carry light cleaning tools		
15. Use carpet sweeper		
16. Clean bathtub		
17. Carry pail of water		

MEAL PREPARATION:		
1. Turn on water		
2. Turn on gas or electric stove		
3. Light gas with match		
4. Pour hot water from pan to cup		
5. Open packaged goods		
6. Carry pan from sink to stove		
7. Open screw top jars		
8. Use can opener		
9. Use can punch		
10. Use bottle opener		
11. Handle milk bottle		
12. Dispose of garbage		
13. Remove things from refrigerator		
14. Bend to low cupboards		
15. Reach to high cupboards		
16. Peel vegetables		
17. Cut up vegetables		
18. Handle sharp tools safely		
19. Break an egg		
20. Stir against resistance		
21. Use measuring cups and spoons		
22. Use flour sifter		
23. Use an egg beater		
24. Remove batter to pan		
25. Mashing: Manual Electric		

HOUSEHOLD ACTIVITIES PERFORMANCE TEST

NAME: _____

MEAL PREPARATION CONT.:

	PARENT OBSERVATIONS	COMMENTS
26. Open oven door		
27. Carry pan to oven and put it in		
28. Stir mixture in pan on stove		
29. Fry item on stove		
30. Cut meat		
31. Use electric frying pan		
32. Roll cookie dough or pie crust		
33. Use electric mixer		
34. Use electric hand mixer		
35. Cut with shears		
36. Make a sandwich		
37. Crack a soft boiled egg		
38. Squeeze citrus fruit		
39. Put on an apron		

MEAL SERVICE:

1. Set table		
2. Carry hot casserole to table		
3. Clear table		
4. Scrape and stack dishes		
5. Wash dishes		
6. Wipe silver		
7. Wash pots and pans		
8. Wipe up stove and work areas		
9. Wring out dish cloth		
10. Put dishes away		
11. Use dishwasher		

LAUNDRY:

1. Sort clothes		
2. Wash lingerie		
3. Wring out, squeeze dry		
4. Hang on rack to dry		
5. Hang on line to dry		
6. Sprinkle clothes		
7. Iron shirt or dress		
8. Fold shirt or dress		
9. Iron flat pieces		
10. Set up & take down ironing board		
11. Use ironer (hand controls)		
12. Use washing machine		
13. Use dryer		

SEWING:

1. Thread needle and make knot		
2. Sew on buttons		
3. Mend rips		
4. Darn socks		
5. Use sewing machine		
6. Knit		
7. Crochet		
8. Embroider		

HOUSEHOLD ACTIVITIES PERFORMANCE TEST

NAME: _____

HEAVY HOUSEHOLD ACTIVITIES:	PARENT OBSERVATIONS	COMMENTS
1. Household laundry - washing		
2. Hanging clothes		
3. Clean range		
4. Clean refrigerator		
5. Wax floors		
6. Turn mattresses		
7. Wash windows		
8. Put up curtains		

MARKETING:		
1. Make out shopping list		
2. Order over the telephone		
3. Put groceries away		

CHILD CARE:		
1. Bathe baby or child		
2. Diaper baby		
3. Dress child		
4. Comb hair		
5. Feed child		
6. Lift child to chair or bed		
7. Put child on floor		
8. Put child in bed or crib		
9. Put child in play pen		
10. Supervise outdoor play		

OTHER SPECIAL TASKS:

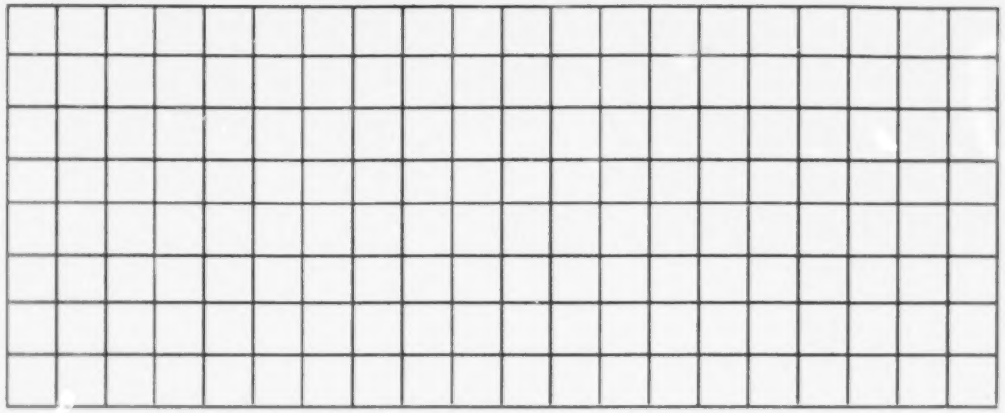
RECORD OF PROGRESS

DATE NOTE

COMMUNITY SKILLS CHECKLIST

COMMUNITY SKILLS--STREET SAFETY

DATE:



__ 1. Can identify where to cross a street, (crosswalks, stop signs, intersections etc.)

__ 2. Looks both ways before crossing

__ 3. Initiates crossing without prompt when it is safe

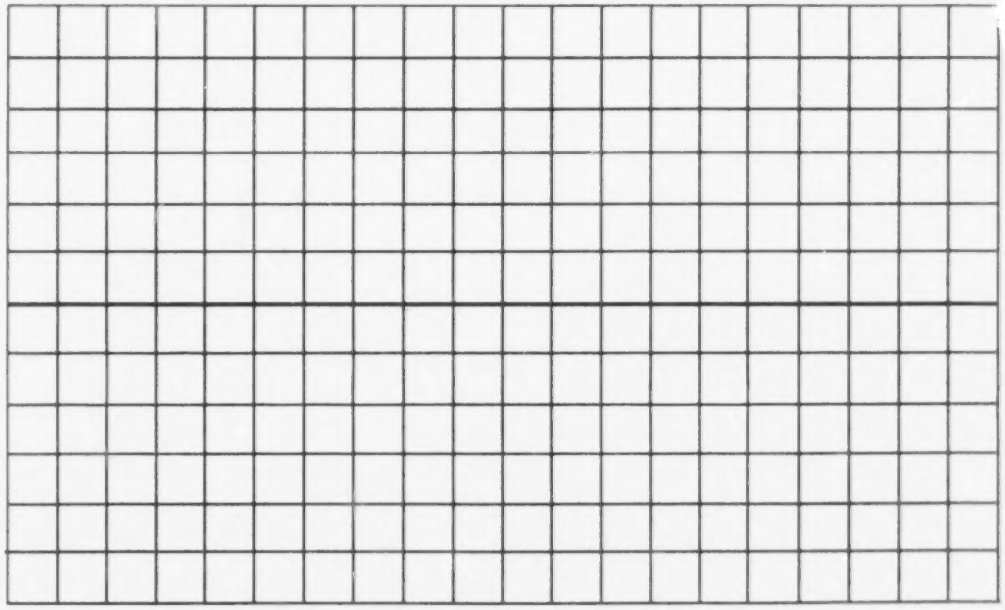
__ 4. If applies, waits for "walk" signal

__ 5. Walks appropriately across street

__ 6. Uses sidewalks versus street

__ 7. Parking lot safety - walks close to parked cars versus in the middle of the lot

COMMUNITY SKILLS - BUS TRAINING



__ 1. Get bus pass

__ 2. Picks out correct amount of money to pay for bus

__ 3. Identifies bus stop

__ 4. Identifies correct route number on bus

__ 5. Boards bus and presents card to driver

__ 6. Deposits fare correctly

__ 7. Requests transfer if necessary

__ 8. Sits in appropriate seats

__ 9. Demonstrates appropriate behavior on bus

__10. Signals driver to stop at correct destination

__ 11. Departs bus safely at destination

__12. Knows procedures for missing bus or getting on wrong bus

STUDENT NAME_____

SCHOOL YEAR _____

STAFF INITIALS_____

N= NEEDS IMPROVEMENT
S= SATISFACTORY
A= ACCOMPLISHED

COMMUNITY SKILLS--USING PROPER ENTRY WAYS

DATE:

__ 1. Identifies where to enter mall or store

__ 2. Uses correct door in or out, entrance, exit, etc.

__ 3. Uses Push or Pull correclty

__ 4. Uses correct door etiquette

__ 5. Uses floor mats to wipe off feet

COMMUNITY SKILLS--PAY TELEPHONE

__1. Locates telephone

__2. Student gets out I.D. card with school number

__3. Waits for dial tone and deposits money

__4. Pushes correct seven digits

__5. Identifies busy signal, ringing, recording and/or operator

__6. Calls school with a message

__7. Can tell school the number they are calling from

COMMUNITY SKILLS--PURCHASING ITEMS

A. IN STORE:

__1. Given an item, student can find appropriate store

__2. Student can locate item in store asking store personnel if necessary

__3. Student locates cashier and presents item appropriately

__4. Pays for purchases with assistance, if necessary

__5. Uses appropriate response with store personnel

B. AT COUNTER:

__1. Student indicates wants appropriately

__2. Student pays for and collects items

__3. Student waits for change

__4. Uses appropriate response with clerk

__5. Obtain condiments, napkins, straws etc. (if applicable)

__6. Displays appropriate manners while eating

__7. Disposes of trash

STUDENT NAME _____

N=NEEDS IMPROVEMENT S=SATISFACTORY A=ACCOMPLISHED

COMMUNITY SKILLS--IDENTIFIES COMMUNITY SERVICES

DATE:

__ 1. Can locate water fountain

__ 2. Can operate water fountain

__ 3. Can locate restroom

__ 4. Independently use restroom

__ 5. Can locate escalators and use independently

__6. Can locate elevator

A. Uses correct button

B. Enters after people inside exit

C. Can locate and operate open door button

D. Knows how to stop automatic door with hand

E. Pushes correct button for desired floor

F. Exits before people enter

__7. Can locate and independently use stairs

__8. Can locate information booth

A. Can ask for assistance and or present ID card in case of an emergency (being lost, hurt, directions)

__ 9. Student identifies - Clothing store for Men

__10. Student identifies - Clothing Store for Women

__11. Student identifies - Shoe store

__12. Student identifies - Card and Gift store

__13. Student identifies - Athletic store

__14. Student identifies - Department store vs. speciality store

__15. Student identifies - Drug store

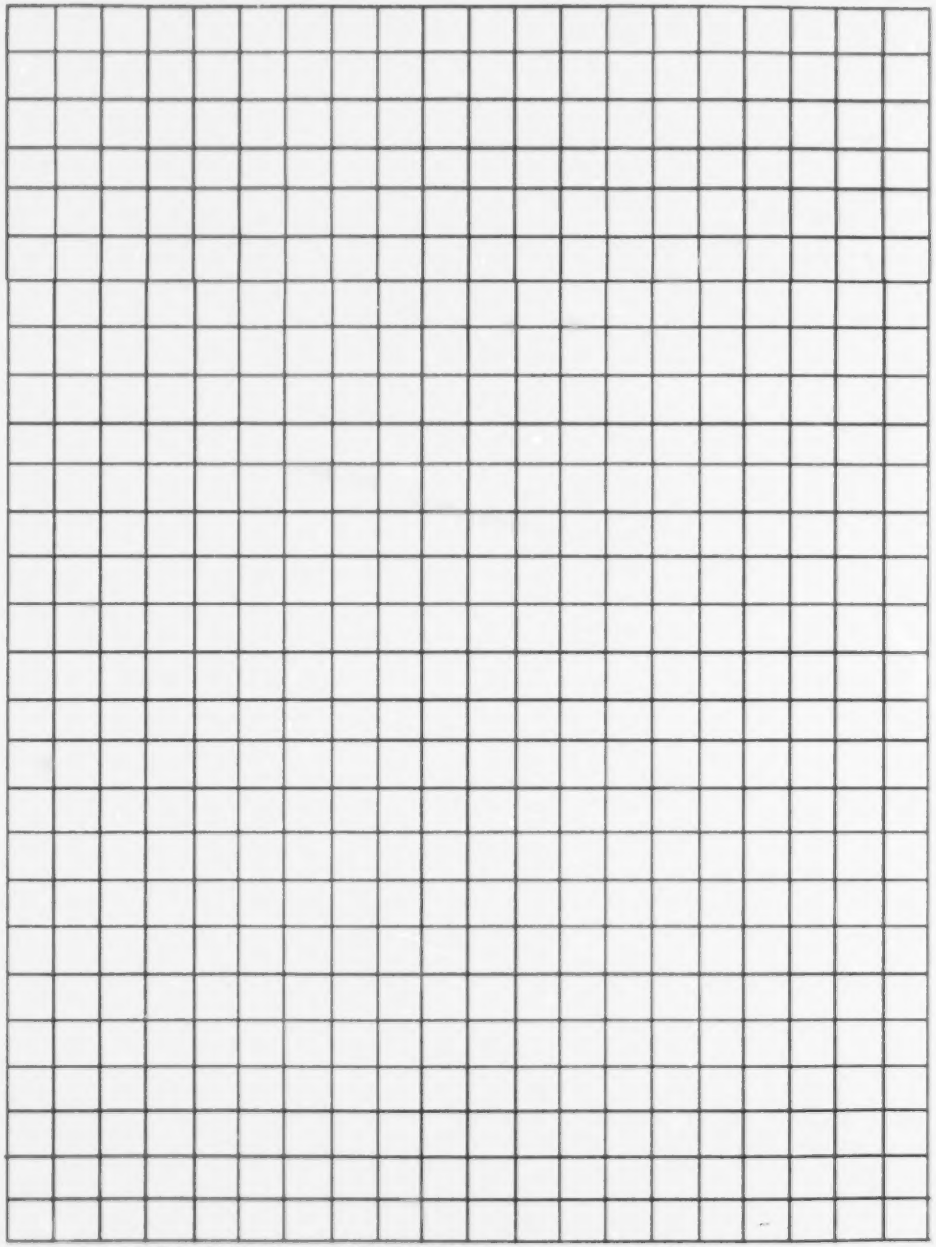
__16. Student identifies - Jewelry store

__17. Student identifies - Music store

__18. Student identifies - Video store

__19. Appropriately interacts with strangers

STUDENT NAME _____



N=NEEDS IMPROVEMENT S=SATISFACTORY A=ACCOMPLISHED

COMMUNITY SKILLS CHECKLIST

Community Skills--Street Safety

--- 1. Can identify sidewalk.
--- 2. Will allow adult to hold hand.
--- 3. Stays with adult or group.
--- 4. Steps off curbs.
--- 5. Steps up over curbs.

Community Skills--Bus training (ambulatory)

--- 1. Sits at bus stop.
--- 2. Walks up stairs to enter bus.
--- 3. Deposits fare in box.
--- 4. Sits in appropriate seat.
--- 5. Walks down stairs to exit bus.

Community Skills--Using Proper Entry Ways

--- 1. Pulls doors open.
--- 2. Walks through door.
--- 3. Steps over threshold.
--- 4. Releases door once in building.

Community Skills--Identifies Community Service

--- 1. Identifies elevator.
--- 2. Rides quietly on elevator.
--- 3. Enters store.
--- 4. Carries purchases to cashier.
--- 5. Hands purchases to cashier.
--- 6. Exits store.

PRE-AMBULATORY SKILLS *

Student demonstrates the ability to:	ASSESSMENT Indep	Part Ind	OBJECTIVES Date Init	Date Achvd	MAX FUNCT LEVEL ACHIEVED
Stand					
assist with dressing and pivot transfers by weight bearing through legs while hanging onto bar or assistant and maintain lower extremity for 30 seconds					
for 60 seconds					
more than 60 seconds					
Sit					
sit in wheelchair supported					
unsupported					
weight shift					
laterally to right					
laterally to left					
anterior/posterior					
sit on toilet supported					
unsupported					
weight shift					
laterally to right					
laterally to left					
anterior/posterior					
Knee Walk					
functional for mobility					
non-functional for mobility					
Creep in Quadruped					
functional for mobility					
non-functional for mobility					
Belly Crawl					
functional for mobility					
non-functional for mobility					
Roll					
to right in bed					
to left in bed					
to right for functional mobility					
to left for functional mobility					

*Developed by Jill Knapp

MOBILITY*

Student demonstrates the ability to:	ASSESSMENT OBJECTIVES: Indep	Part Indep	Date Init	Date Achvd	MAX FUNCT LEVEL ACHIEVED
Walk					
independent (without equipment)					
functional					
non-functional					
with crutches					
functional					
non-functional					
with walker					
functional					
non-functional					
other equipment					
Negotiate/maneuver through the environment:					
bus lift					
stairs					
curbs					
ramps					
on grass					
on snow/ice					
can open doors					
can close doors					
can rise from floor					
can use elevator					
Can transfer to:					
bed					
toilet					
tub					
shower					
school chair/table chair/shower chair					
classroom desk					
lunchroom bench					
car					
Can transfer from:					
bed					
toilet					
tub					
shower					
school chair/table chair/shower chair					
classroom desk					
lunchroom bench					
car					

* Developed by Jill Knapp, R.P.T.

WHEELCHAIR MOBILITY

Student demonstrates the ability to:	ASSESSMENT Indep	Part Ind	OBJECTIVES Date Init	Date Achvd	MAX FUNCT LEVEL ACHIEVED
Move wheelchair by:					
pushing with arms					
pushing with one arm					
using both feet					
using one foot					
Weight shift:					
anterior/posterior					
lateral: Right					
Left					
Navigate wheelchair:					
up curb					
down curb					
up ramp					
down ramp					
on grass					
on snow					
on ice					
elevator					
onto bus lift					
off bus lift					
to open a door					
to close a door					
in a hallway					
in a classroom					
small, enclosed area (similar to bus)					
Transfer into wheelchair from:					
standing					
floor					
toilet					
bed					
school chair/table chair/ shower chair					
car					
bathtub					
classroom desk					
lunchroom bench					
Transfer out of wheelchair to:					
standing					
floor					
toilet					
bed					
school chair/ table chair/ shower chair					
car					
bathtub					
classroom desk					
lunchroom bench					

HYGIENE - DRESSING*

Student demonstrates the ability to:	ASSESSMENT		OBJECTIVES		MAX FUNCT. LEVEL ACHIEVED
	Indep	Part Indep	Date Init	Date Achvd	
Undo clothes for bathroom needs					
Unfasten seatbelt					
Swing away footrests; store crutches/walker					
Transfer to toilet seat					
Catheterize self					
Wipe self					
Flush toilet					
Transfer off toilet seat					
Redo clothes					
Fasten seat belt					
Return footrests; retrieve crutches/walker					
Wash hands/face					
Transfer to tub/shower					
Turn faucets on when bathing					
Turn faucets off when bathing					
Wash body					
Rinse body					
Wring out washcloth					
Shampoo hair					
Rinse hair					
Transfer out of tub/shower					
Dry body					
Dry hair					
Comb/brush hair					
Curl hair					

* Developed by Janice Schott, O.T.R.

HYGIENE - DRESSING P. 2

Student demonstrates the ability to:	ASSESSMENT		OBJECTIVES		MAX FUNCT. LEVEL ACHIEVED
	Indep	Part Indep	Date Init	Date Achvd	
Put on lotion and deodorant					
Squeeze toothpaste on toothbrush					
Brush teeth					
Clean nails					
Trim nails					
Take off glasses/hearing aides					
Unfasten braces					
Take off braces					
Take off belt					
Unbutton front buttons					
Unbutton cuff buttons					
Take off blouse/shirt/dress					
Take off T shirt					
Unzip a non-separating zipper					
Unsnap, unbutton slacks					
Take off slacks/skirt					
Take off socks					
Take off shoes					
Take off undershorts/panties					
Take off bra					
Turn clothes inside out					
Dress for bed					
Transfer to bed					
Pull covers up					

Student demonstrates the ability to:	ASSESSMENT		OBJECTIVES		MAX FUNCT. LEVEL ACHIEVED
	Indep	Part Indep	Date Init	Date Achvd	
Turn off lights					
Transfer out of bed					
Take nightclothes off					
Select own clothes for dressing					
Put on undershorts/panties					
Put on bra					
Put slacks/skirt on					
Zip a non-separating zipper					
Put on T shirt					
Put on blouse/shirt/dress					
Button front buttons					
Button cuff buttons					
Put belt through loops and fasten					
Put on socks					
Put on shoes					
Lace shoes					
Tie shoes					
Put on braces					
Fasten braces					
Clean glasses					
Put on glasses/hearing aides					
Put on sweater/coat					
Connect and zip a separating zipper					
Open/close safety pins					

Student demonstrates the ability to:	ASSESSMENT		OBJECTIVES		MAX FUNCT. LEVEL ACHIEVED
	Indep	Part Indep	Date Init	Date Achvd	

COMMENTS:

SCHOOL ACTIVITIES*

Student demonstrates the ability to:	ASSESSMENT		OBJECTIVES		MAX FUNCT. LEVEL ACHIEVED
	Indep	Part Indep	Date Init	Date Achvd	
Open door					
Turn on lights					
Take off coat					
Take items out of backpack					
Put coat/backpack in appropriate place					
Open seatbelt on wheelchair					
Swing away footrests; store crutches					
Transfer into school chair					
Turn pages					
Use pencil/eraser					
Sharpen pencil (electric/manual)					
Use scissors					
Use ruler					
Use glue					
Use compass					
Use paper clips					
Use rubber bands					
Use stapler					
Use scotch tape					
Fold papers					
Put materials into correct folders					
Put folders in appropriate place					
Put items in desk					
Maintain order of desk					
Put homework/notes to go home in backpack					

*Developed by Janice Schott, O.T.R.

SCHOOL ACTIVITIES P. 2

Student demonstrates the ability to:	ASSESSMENT		OBJECTIVES		MAX FUNCT. LEVEL ACHIEVED
	Indep	Part Indep	Date Init	Date Achvd	
Show responsibility for pencils/papers/books					
Show responsibility for cup/straw					
Get drink at water fountain					
Find way around school					
Play safely on playground					
Pick up something from floor					
Carry food tray					
Open milk carton					
Eat independently					
Return plate/silverware to kitchen					
Clean off table or wheelchair tray					
Pick up/dial telephone					

COMMENTS:

123

EATING - FOOD PREPARATION*

Student demonstrates the ability to:	ASSESSMENT		OBJECTIVES		MAX FUNCT. LEVEL ACHIEVED
	Indep	Part Indep	Date Init	Date Achvd	
Eat finger foods with fingers					
Eat with a spoon					
Eat with a fork					
Spread with knife					
Cut with knife/fork					
Drink from cup/glass					
Use straw					
Use salt/pepper shaker					
Use napkin					
Get drinks from refrigerator					
Pour liquids from small container (pint)					
Pour liquids from large container (1-2 quarts)					
Knows where specific foods are kept in kitchen					
Open cabinets/drawers in kitchen					
Take items from shelf					
Open cereal box and inside wrapper					
Prepare dry cereal to eat					
Gathers items to make sandwich					
Open screw top lids					
Prepares sandwich					
Turns on/off faucet to get drink					
Open bags					
Open boxes					
Open zip type bags					

*Developed by Janice Schott, O.T.R.

EATING - FOOD PREPARATION P.2

Student demonstrates the ability to:	ASSESSMENT		OBJECTIVES		MAX FUNCT. LEVEL ACHIEVED
	Indep	Part Indep	Date Init	Date Achvd	
Open/close twist ties					
Open pull top tabs on cans					
Open pull top plastic tabs					
Open/close plastic lids (restorage containers)					
Open can with hand held/electric can opener					
Wipe kitchen countertop					
Rinse dishes					
Put dishes in dishwasher					

COMMENTS:

ADULT ACTIVITIES OF DAILY EVALUATION *

NAME _____ BIRTHDATE _____

DIAGNOSIS _____ HANDEDNESS _____

POSSIBLE SCORE 52 _____ SCORE _____

A. HYGIENE				**C. UTILITIES**			
1. Comb or brush hair				19. Make change			
2. Brush teeth				20. Take bill from wallet			
3. Shave or put on makeup				21. Use scissors			
4. Wash hands and face				22. Wind clock or watch			
5. Clean/trim nails				23. Operate light switch			
6. Care of bathroom needs				24. Operate faucets			
7. Bathe adequately				25. Plug in cord			
B. DRESSING				26. Open/close door (lock)			
8. Shoes off				27. Strike match			
9. Shoes on				28. Open/close cabinet			
10. Shirt or coat off				29. Open/close door latch			
11. Shirt on (buttons)				30. Push door bell			
12. Pants or slip off				31. Operate safety pin			
13. Pants on (zipper)				32. Open/close bottle			
14. Socks or stockings off				33. Open can			
15. Socks on				34. Stir feed			
16. Underclothes on and off				35. Operate stove			
17. Braces on and off				36. Make bed			
18. Handle appliances				37. Use iron			
(glasses, hearing aid)				38. Get in and out of car			
				39. Use public transportation			
D. EATING				**E. COMMUNICATIONS**			
40. Eat with a spoon				47. Read			
41. Eat with a fork				48. Write (name/address)			
42. Cut with knife/fork				49. Turn pages			
43. Drink from cup or glass				50. Fold letter			
44. Use straw				51. Pick up and dial phone			
45. Use salt shaker				52. Speech (name/address)			
46. Spread butter on bread							

*Developed by the Jefferson County Community Centered Board

PLEASE USE OTHER SIDE FOR COMMENTS

BASIC FUNCTIONAL CURRICULUM *

I. PERSONAL AND SOCIAL SKILLS

A. Attending behavior
B. Self control
C. Manners
D. Self identification
E. Personal grooming
F. Appropriate conversation
G. Introductions
H. Realistic goals
I. Realistic life goals
J. Appropriate interpersonal relationships
K. Self-esteem
L. Personal etiquette
M. Use of the phone

II. FUNCTIONAL VOCATIONALLY-ORIENTED ACADEMICS

A. Reading
1. Community Words
a. Survival signs - danger, exit, etc.
b. Grocery vocabulary
c. Department store logos
d. Application vocabulary
e. Banking vocabulary
2. Reading and following directions
3. Functional parts of a newspaper
4. Reading bus schedules

B. Time Skills
1. Telling time
2. Setting an alarm clock
3. Calendar/Holiday/Seasons
4. Time planning
5. Time sheet procedure
6. Using bus schedules or modified bus schedules

C. Money Skills
1. Identification and values
2. Basic counting
3. Reading price tags
4. Savings accounts

5. Checking accounts
6. Budgeting money

D. Math Skills
1. Counting
2. Basic addition and subtraction
3. Calculator skills
4. Basic measuring skills

E. Handwriting
1. Imitates letters and numbers
2. Copies letters, words and numbers
3. Legibility and sizing
4. Signatures
5. Endorsing checks
6. Completing applications
7. Completing bank forms

III. PEOPLE, EVENTS, PLACES

A. Home
B. School
C. Neighborhood
D. Community
1. Airport
2. Arvada Center
3. Bakery
4. Bank
5. Bowling Alley
6. Capital
7. Car Wash
8. Circus
9. Cleaners/Laundromat
10. Dentist/Doctor
11. Fire/Police Station
12. Funtastic
13. Gas Station
14. Library
15. Movie Theater
16. Post Office
17. Roller Skating Rink
18. RTD
19. Schools
20. Sporting Goods Store

21. Train Station
22. Veterinarian
23. Video Arcade
24. Yogurt/Ice Cream Shop
25. Zoo

E. City
F. State
G. Country
H. World

IV. COMMUNITY SKILLS

A. Street safety
B. Using public transportation systems
C. Locating a telephone and making emergency phone calls
D. Emergency procedures when lost
E. Appropriate behavior
F. Appropriate behavior with strangers
G. Locating restrooms
H. Problem solving in community situations
I. Reading price tags
J. Making purchases - grocery, department stores
K. Restaurant purchasing
L. Locating departments
M. Using informational directory
N. Banking skills
O. Laundromat skills
P. Recreational facilities - movies, bowling, skating, etc.

V. JOB READINESS - RELATED VOCATIONAL SKILLS CLASS
(See B-Wing World of Work Curriculum)

A. Occupational areas - General information
B. Identifying interests
C. Completing job applications, W-4 forms, and emergency cards
D. Interview techniques
E. Worker characteristics
F. Job safety
G. Following directions
H. Following Job Directions List---picture and/or written
I. Problem solving
J. Seeking help when needed
K. Calling-in sick or late
L. Identifying and correcting mistakes

M. Employer-employee roles
N. Accepting criticism
O. Time clock--Time sheets
P. Parts of a paycheck
Q. Handling a paycheck

VI. VOCATIONAL SKILLS TRAINING (Specific Hands-On Training)
(See B-Wing World of Work Curriculum)

A. General occupational motor skills training
   1. Following directions
   2. Accuracy
   3. Speed
   4. Endurance
B. Animal care skills
C. Laundry service skills
D. Janitorial-Housekeeping skills
E. Horticulture skills
F. Child care skills
G. Food service skills
H. Clerical-Office skills
I. Auto detailing skills
J. Grounds maintenance skills

VII. ON-THE-JOB TRAINING

A. Classroom jobs
B. In-school jobs
C. Community job shadowing
D. Community Work Crews
E. Community On-the-Job Training

* Developed by the Jefferson County Community Centered Board

APPENDIX E

EXAMPLES OF CASELOADS AND DELIVERY SYSTEMS

Caseloads and Service Delivery

Example #1
American Occupational Therapy Association

Determination of Caseload

A number of variables influence the appropriate number of students on the caseload of an occupational therapist in the schools:

1. Type and severity of handicapping conditions of students.

2. Type and amount of assessment and intervention.

3. Geographic area to be covered by the itinerant therapist and amount of travel time required.

4. Other duties required of the therapist such as keeping records, attending meetings, attending diagnostic staffings, educating parents, conducting research, and more.

5. Amount of support available from aides, assistants, and clerical personnel.

6. Number of community contacts required with other agencies and physicians.

7. Type of space and equipment available.

8. Amount of inservice training the therapist must take to develop needed skills.

The amount of time available for intervention, direct treatment, and monitoring classroom programs may vary from one setting to another. The school year calendar may also cause variety. For example, more hours are needed at certain times during the school year for IEP meetings, planning meetings, and documentation, while at other times there is a greater need for evaluation and screenings. Adjustments must,

therefore, be made if scheduling conflicts prevent the therapist from making maximum use of his or her time of if the therapist has additional supervisory responsibilities. Three to five hours per week should be allotted for each person supervised, depending on the para-professional's skill level. An aide with only the basic training needs daily supervision, whereas an experienced COTA may need less. The following is a breakdown of a therapist's typical week:

Work Week

Total working hours per week	37.5
Assessment	-5.0
IEP staffings and meetings	-3.0
Consultation	-2.0
Lunch	-2.5
Balance	25.0

The remaining 25 hours are available for a caseload of students including documentation, preparation, and planning. Note that the hours listed for assessment and for consultation include time for documentation and information gathering.

Caselaod for Therapist

The maximum number of students on a therapist's caseload is directly related to the types of assessment and intervention required. The following outline of the service delivery pattern discussed earlier forms a basis for the caseload formula.

I. Assessment

A. Screening

1. Type 1 (identify from the larger population)

2. Type 2 (determine need for further assessment)

B. Evaluation

C. Reassessment

II. Program Planning

III. Intervention

A. Direct Therapy

1. Individual

2. Small group

B. Monitoring

C. Consultation

1. Case Consultation

2. Colleague Consultation

3. System Consultation

The formula that is used to determine caseloads considers the variables of travel time, supervision given, and type of service delivery. Documentation of time, consisting of notes, reports, charts, planning, and preparation, is computed on a 1:4 ratio, or 1 hour of documentation for every 4 hours spent with students. As a general rule, intervention patterns require the following amount of time per week:

DI - *Direct, individual,* based on one student per 1/2-hour session two times per week plus 1/4-hour documentation (1 hour + .25 hour =

1.25 hours per student). If treating 1/2 hour, one time per week, use .625 per student.

DG - *Direct, group,* based on group of four students, 1 hour, two times per week (1/2 hour per student) plus 1/8-hour documentation (.5 hour + .125 hour = .625 hour per student).

M - *Monitoring,* regular contact with student and/or teacher of 1/2 hour per week plus documentation (.625 hour per student).

T - *Travel,* time between schools per week (actual time).

S - *Supervision,* time for occupational therapy aides and assistants (3 to 5 hours per week for each person supervised).

ITA - *Intervention time available.*

The formula for determining ITA is 25 hours minus the amount of time devoted to travel and supervision:

ITA = 25 minus T minus S

Caseload numbers can be computed using this formula:

ITA = 1.25 DI + .625 DG + .625 M

In this formula, the number of hours available for ITA equals the number of students in each intervention model (DI, DG, or M) multiplied by the time needed for each student.

Caseload for Assistants

The caseload for an occupational therapy assistant is computed in a manner similar to that used for computing the caseload of the occupational therapist. For the typical occupational therapy assistant, 25 hours are available for direct intervention on a group or individual basis, with adjustments for travel. Three

hours per week are needed for supervision from the occupational therapist, 2 hours are spent in IEP meetings and other meetings, and the remaining 5 hours are spent with a variety of duties, which may include assisting with assessment and screenings, inventory control, ordering supplies, maintaining files for audit, and inservice training.

Nonitinerant Therapist

The therapist with no travel or supervisory responsibilities whose entire caseload receives individual therapy calculates a maximum caseload as follows:

Example

ITA = 1.25 DI

25 = 1.25 DI

25/1.25 = DI

DI = 20

The maximum caseload for this therapist is 20 students.

If a therapist's entire caseload is to be on a monitoring intervention model with no travel or supervisory responsibilities, the caseload is as follows:

ITA = .625 M

25 = .625 M

25/.625 = M

M = 40

The maximum caseload is 40 students.

By substituting the number of intervention hours available in the formula, the therapist can determine the appropriate number of students on a mixed caseload. Conversely, by substituting caseload numbers in the formula, it can be determined how many therapy hours

per week are required and the number of therapists needed for the caseload.

Itinerant Therapist Example 1

An itinerant therapist travels 5 hours per week between schools. Half the intervention time is spent in monitoring and half in direct individual sessions. The therapist's intervention time available is 20 hours (ITA = 25 - T), 10 hours each for monitoring and individual sessions. Time for monitoring students equals the ITA divided by .625; therefore, the therapist can have 16 students for monitoring (10/.625 = 16). The number of students for individual sessions equals the intervention time available divided by 1.25, or 8 students. The therapist's maximum caseload is 24 students. The following example is calculated according to the formula:

1/2(25 - T) = .625 M	1/2(25 - T) = 1.25 DI
1/2(25 - 5) = .625 M	1/2(25 - 5) = 1.25 DI
20/2 = .625 M	20/2 = 1.25 DI
10 = .625 M	10 = 1.25 DI
10/.625 = M	10/1.25 = DI
M = 16	DI = 8

This therapist can handle a maximum of 24 students.

Itinerant Therapist Example 2

A therapist travels 3 hours per week between schools, has a caseload of 12 students for individual therapy, and has been requested to work with additional students in small groups. The therapist must determine how many students can be added. Intervention time available (ITA) is 22 hours (25 - T = 22). The time needed for individual students is the number of students times 1.25, or 15 hours, which leaves 7 hours available for group sessions. The number of students that can be added for group sessions equals the ITA divided by .625, or 11.2 (7/.625 = 11.2). The

therapist can add 11 students for a total caseload of 23.

$$25 - T = 1.25\ DI + .625\ DG$$

$$25 - 3 = 1.25\ (12) + .625\ DG$$

$$22 = 15 + .625\ DG$$

$$22 - 15 = .625\ DG$$

$$7 = .625\ DG$$

$$DG = 7/.625$$

$$DG = 11$$

Itinerant Therapist Example 3

School district XYZ has 78 students who require occupational therapy services. It is estimated that that 18 need individual intervention, 32 students need group sessions, and 28 need monitoring. The school district needs to determine how many itinerant therapists to hire (each will travel 5 hours per week). The students who receive individual help will need 22.5 hours per week (1.25 times 18); those needing group sessions will require 20 hours (.625 times 32); and monitoring will require an additional 17.5 hours for the 28 students (.625 times 28). That is a total of 60 hours of intervention needed by occupational therapists. therapist will have 20 hours available because of 5 hours of travel, so the district needs three occupational therapists.

$$X(25 - T) = 1.25\ DI + .625\ DG + .625\ M$$

$$X(25 - 5) = 1.25(18) + .625(32) + .625(28)$$

$$X(20) = 22.5 + 20 + 17.5$$

$$X(20) = 60$$

$$X = 3$$

CASELOAD EXAMPLES

The following are examples of caseload numbers that were obtained by applying the formula. A maximum of 40 students is recommended.

1. Therapist spends 50% of intervention time with students in groups and 50% in individual sessions.

   No travel - 30 (20 group, 10 individual)

   2 hrs. travel/week - 27 (18 group, 9 individual)

   4 hrs. travel/week- 24 (16 group, 8 individual)

   6 hrs. travel/week- 21 (14 group, 7 individual)

2. Therapist spends 75% of contact time with group sessions and 25% in individual sessions:

   No travel - 35 (30 group, 5 individual)

   2 hrs. travel/week - 32 (27 group, 5 individual)

   4 hrs. travel/week - 28 (24 group, 4 individual)

   6 hrs. travel/week - 25 (21 group, 4 individual)

3. Therapist spends 100% of contact time in group sessions:

   No travel.- 40

   2 hrs. travel/week - 36

   4 hrs. travel/week - 33

   6 hrs. travel/week - 30

4. Therapist spends 100% of contact time in individual sessions:

   No travel.- 20

2 hrs. travel/week - 18

4 hrs. travel/week - 16

6 hrs. travel/week - 15

The average school-based itinerant occupational therapist can assume a caseload of 20 to 40 students, with a maximum of 40 students including both direct treatment and monitoring classroom programs. If it is anticipated that additional students will be added from assessments made during the school year, then it is recommended that a therapist begin the school year with less than a maximum caseload.

Example #2

Logistics: Scheduling

by
Jennifer York

Before recommending specific strategies for scheduling team members to assist in integrated programming, several general considerations mentioned earlier in this paper will be reviewed. First, when initially committing to a team approach, immediate teamwork and program excellence should not be expected. Developing effective teamwork takes time. Each team must develop a style and an approach for collaboration and communication. An addition or deletion of just one team member can dramatically change the group dynamics and interaction. Initially, each person will need to gain confidence in sharing information, making suggestions, problem-solving, and receiving feedback from other team members. Compromising and presenting oneself as a learner, as well as a person with valuable information, are critical attributes for all team members.

Second, inherent in an integrated model of service delivery is more flexibility in scheduling than is typical for support personnel. Additionally, there are high expectations for all team members to share the workload and contribute proportionately. These characteristics of an integrated service delivery model require a high degree of accountability. Each team member is responsible for ensuring a high quality of service delivery in all aspects of a student's educational program. Especially when working with students who have multiple and often complex learning styles and needs, no one discipline or person can adequately address all programming needs. It is only through collaborative planning, programming, brainstorming and problem-solving that comprehensive, balanced and individually appropriate programs can be developed and implemented. This requires maturity and responsibility on the part of every team member. All must be concerned about the outcomes of the student's educational career. Will his or her education have provided the instructional experiences necessary for living an integrated, normalized, and fulfilling life as an adult in their communities?

Third, organization is essential for effective teamwork. There must be consistent expectations for students. If a student is taught to perform a

task in one way on Monday, and the next day it is taught in a different way by another person, the student will have difficulty learning. When consistency in programming expectations, instructional strategies and adaptations is provided, the chance of student learning is greatly enhanced. One way in which consistency can be achieved is by utilizing on-site demonstrations and working with students in natural instructional environments. This allows for specific programming information to be communicated between instructors and support personnel. A second way for providing consistency is to have all I.E.P.s, instructional program sheets, data sheets and graphed information easily accessible to all team members. The task force found it helpful to keep an organized three-ring binder located in the classroom for each student that contains all of the student's written programming information.

Scheduling of team members into classroom and community environments to work with students, and scheduling for team meetings to work together must also be well organized. Expectations for participation by all team members must be clearly delineated. Strategies for scheduling time with students and the nature of the student and team member interactions during this time will be specifically addressed here.

Block scheduling is one strategy used to provide support personnel the opportunity to work with students and other team members in actual community environments and in naturally occurring daily activities at school or in the student's home. Given the number of students assigned to each classroom and respective support personnel needs, support personnel are assigned to classrooms for blocks of time, instead of pulling students from class or other instructional environments to be worked with in isolation. Blocks can be any amount of time, such as two hours, a half day, a full day, all day Mondays and Wednesdays, etc. The main premise is that support personnel must be assigned to observe and work with students in natural environments where they typically receive instruction. This enables all professionals to accurately determine environmental demands and student abilities, and to develop instructional and adaptation strategies. An example of a monthly schedule for one occupational therapist is presented in Figure 8A. A specific schedule for a one day block schedule is presented in Figure 8B.

Task force members agreed that for most students with severe disabilities, it is more important for support personnel to spend a long block of time assigned to a specific group of students less frequently, than to spend shorter blocks of time on a more frequent basis. For example, in one teacher's class, there are four students who require the

expertise of a physical therapist. Given the students' needs and the therapist's caseload, it was decided that approximately three hours a week could be spent with these students. The teacher and therapist chose to schedule the therapist every other Monday for a six-hour block of time. This resulted in approximately six hours spent every two weeks instead of three hours every week.

Spending an entire day, or a large part of the day, with one class provides support personnel the opportunity to become integrated members of the educational team responsible for student programming. It also provides an open block of time for the teacher and each support person to jointly determine high priority needs that must be addressed on the day scheduled for consultation and observation. For example, it was decided that the physical therapist would spend the first part of the designated morning working with students and the primary instructor during the community mobility activities encountered when traveling to a work site. Later in the morning, the therapist met two other students and a primary instructor at one of the student's homes being used as a community domestic training site. There she assisted in developing a positioning strategy for one student during a cooking activity. She also developed a transition sequence for the student who lived in that home to get out of his family car, across the lawn and up the steps into the house. After these on-site consultations occurred, specific recommendations and program changes were delineated and necessary adaptations were made by the therapist and primary instructor.

Some special education programs that have incorporated the use of block scheduling have encountered difficulties with ensuring appropriate use of team members' time spent with students and with each other. Therefore, several recommendations are provided to maximize appropriate use of staff time.

1. Regularly scheduled blocks of time must be agreed upon by teacher and support personnel. During these blocks of time, the support personnel must be working with the designated students and respective instructors, or in other priority tasks as determined by both the teacher and support person.

2. In most situations, support personnel should not be used during the block of time as an "extra pair of hands" or assigned to work independently with a group of students. The scheduled block of time is intended for the primary instructor, the student(s) and the support person to work together on instructional

programming, problem-solving, brainstorming, teaching each other, etc. This ensures that when the support person is not present in the instructional environment, their expertise will be integrated into the natural activities and carried out by the primary instructor.

3. Support personnel must not adopt a "never get my hands dirty, I am the expert role" in which they give the primary instructor verbal directions, then exit. They must work directly with students to determine intervention procedures or modifications. Then they must teach the primary instructor those procedures prior to expecting carry-over and follow-through.

4. Support personnel must have the opportunity to work "hands-on" with students in order to actually know what a student needs and how learning may be enhanced. This can and should be done in the context of naturally occurring instructional situations. In addition, it is beneficial to reverse the roles during some activities so that the support person temporarily assumes the role of instructor (with the primary instructor present). Most become acutely aware of the difficulty in providing precise instruction to students, while attending simultaneously to optimal positioning, relaxation, communication and other aspects of performance.

5. Teachers must monitor instructional assistants' interactions with students to ensure that instructional programs proposed by support personnel are carried out.

A specific process for use of blocks scheduled times may also be helpful. The following list provides a sequence for use of block scheduling time assignments to classrooms and/or groups of students.

1. On the day of the scheduled block time, the teacher and support person jointly determine who will be worked with in specific environments and activities.

2. When working in the prioritized situations, a variety of interactions are used. These include: observing, "hands-on" assessment and problem-solving, brainstorming instructional or adaptation modifications, teaching the primary instructor new intervention procedures, and analyzing data and the effectiveness of the data collection strategies.

3. After working in the actual environments and activities, written documentation of agreed upon intervention strategies, changes, or responsibilities (e.g., modifying a communication book or making a microswitch adaptation) should be delineated.

4. If it is not possible to work with all necessary students during the block of time, priorities for the next scheduled block of time should be outlined.

Example #3

Job Responsibilities and Caseload Size

School Administrator's Guide

to

Physical Therapy and Occupational Therapy

in

California Public Schools

Job Responsibilities and Caseload Size. In order to meet children's needs and the changing needs of the program, it is important that therapists have sufficient time for planning sessions, I.E.P. meetings, report writing, travel, program evaluation and inservice training. In particular, an itinerant therapist may spend considerable time traveling between school sites. Travel time may average one-half hour each direction to each site. Equipment set up will also increase time needed. To increase service delivery, evaluations and treatments should be scheduled so that all children in a geographic area are seen at one time.

A general description of job responsibilities and guidelines on time breakdown for a full-time itinerant staff therapist employed by an educational agency are listed below. The information was compiled from a survey of occupational therapists and physical therapists employed by educational agencies in three counties in the San Francisco Bay Area.

58% Screening and assessment, direct treatment, consultation and instruction of supportive personnel. If the itinerant therapist is also involved in supervision of other therapists and/or aides, treatment time will decrease proportionately. Approximately 25% time will be needed to supervise three persons.

19% Telephone contacts, budgeting, charting, grading tests, report writing, make/repair/design/order equipment, ongoing needs assessment, informal discussions with parents/teachers, exchange written information.

11-20%	Travel to school sites, set up, clean-up of treatment area.
8%	I.E.P. meetings, staff meetings, coordination with other disciplines.
2%	Formal and informal inservice training to parents and educational staff.
2%	Continuing education and other professional enhancement activities.
100%	

A therapist hired on contract can also function on an itinerant basis; therefore, the above time guidelines may apply.

Current nationwide surveys by the American Occupational Therapy Association show that on an average, one therapist can provide direct treatment to approximately 11 to 25 children per week as well as consultative services for 1 to 10 children per week. A survey of occupational therapists and physical therapists employed as staff by educational agencies in eight counties in California provided further support to the AOTA surveys. Full-time therapists reported serving an average combined caseload of 30 children per week for direct and consultative services.

Caseload for therapists hired on a contractual basis will be dependent upon the number of hours per week and the range of responsibilities agreed upon in the contract between therapist and educational agency. Since many factors affect caseload size of a therapist, the reader is cautioned in the use of average therapy caseload numbers.

Example #4

Waukesha Guidelines

Service Delivery Model

All students receiving occupational/physical therapy services are assessed and assigned one of four levels of service. The levels of service are based on the rate of change in the student's physical/functional status and may change during the school year. Each level of service defines the purpose of intervention, intensity of service, and the personnel responsible for the delivery of services. Therapists are involved in evaluation, therapy service planning, parent/staff training, and monitoring of student's programs.

Level	Physical/Functional Status of Student	Purpose of Intervention	Intensity of Service	Therapist/Staff Involvement
I	Student is undergoing rapid and/or crucial changes in physical/ functional status.	Therapy goals are designed to develop functional level or prevent significant regression.	Time commitment may range from 2 1/2 - 3 1/2 hours per week; of that, 2/3 is targeted on time with student, 1/3 is targeted time on behalf of student. Therapy revisions are frequent.	Physical needs are primarily addressed by the therapist by providing specific therapy techniques, with other personnel involved as appropriate in order to provide a "therapeutic day."
II	Student is undergoing moderate changes in physical/functional status, up or down.	Therapy goals are designed to develop functional level.	Time commitment may range from 1 1/2 - 2 1/2 hours per week; of that, 2/3 is targeted as time with student, 1/3 is targeted time on behalf of student. Therapy revisions are periodically necessary.	Physical needs are addressed by the therapist by providing specific therapy techniques, with other personnel involved as appropriate in order to provide a "therapeutic day."
III	Student's physical/ functional status is undergoing some changes or is stable.	Therapy goals are designed to develop and/or maintain functional level..	Time commitment may range from 1/2 - 1 1/2 hours per week; of that, 2/3 is targeted as time with student, 1/3 is targeted time on behalf of student. Therapy revisions are infrequent.	Therapist is now in a more supportive role, with other personnel involved as appropriate in order to provide a "therapeutic day."
IV	Student's physical/ functional status is stable.	Therapy goals are designed to monitor functional and physical status.	Time commitment is up to 20 hours per school year. Contact frequency may vary (bi-monthly, monthly, quarterly). Student may be placed on Level IV to monitor status prior to dismissal.	Therapist will monitor on a needs basis, providing input on student's needs. Other personnel may continue to follow through on recommendations to help maintain student's physical/functional status.

Example 5

Determination of Caseloads

State of Washington

Total Working Hours per Week - FTE Physical Therapist
(Taken from Tacoma Public Schools caseload survey February, 1986)

		Itinerant PT	Schoolbased PT
Contract Conditions*		(20%) 7.50 hours	7.50 hours (20%)
Student Contact	(44%)	16.50 hours	17.30 hours (46%)
Paperwork	(14%)	5.25 hours	4.90 hours (13%)
Meetings, I.E.P.	(11%)	4.10 hours	7.80 hours (21%)
Travel	(11%)	4.10 hours	0.00 hours
Total		37.50 hours	37.50 hours

* Contract Conditions

Lunch time	2.5 hours
Breaks	2.5 hours
Planning time	2.5 hours
Total	7.5 hours

Balance of time for treatment after subtracting required activities:

Total Working Hours per Week 37.5
(Taken from Michigan Alliance of School PTs and OTs March, 1986)

Assessment	-2.5 hours
Documentation, Planning, Preparation	-2.5 hours
I.E.P. Staffings and meetings	-2.5 hours
Consultation	-2.0 hours
Lunch	-2.5 hours
Balance (Intervention time)	25.0 hours

Clearly, these hours are theoretically available, but do not indicate what is actually available to any given therapist. There are innumerable

variables such as travel time, scheduling conflicts, liaison work with community resources, student assessments, supervisory responsibilities, inservices to staff, etc. These variables directly influence the time actually available for student contact.

In summary, caseload numbers can be determined by examining both the categorization of student needs and the amount of time actually available to fulfill the I.E.P. recommendations.

Caseload Determination

The number of students on the caseload of a physical therapist in the schools may be influenced by the following:

a. Type and severity of handicapping conditions of students; number of students with high, mild, or low priority needs
b. Type and amount of assessment and intervention
c. Geographic area to be covered by the itinerant physical therapist and amount of travel time required
d. Other duties required by the therapist such as keeping records , attending meetings, diagnostic staffings, educating parents, conducting research, etc.
e. Amount of support available from aides, assistants, and clerical personnel
f. Number of community contracts required with other agencies and physicians
g. Type of space and equipment available
h. Amount of inservice training the physical therapist must take to develop needed skills
i. Amount of inservice training the physical therapist must provide to develop needed skills of classroom staff

Example #6

Determining School Therapy Caseloads Based Upon Severity of Need for Services

by
Susan K. Effgen

During the past several years, the Georgia Alliance of School Occupational and Physical therapists have developed and tested a rating scale for students receiving therapy in the public schools. The scale grew from the necessity of determining which students were of the highest priority for the limited therapy services available in Georgia. The rating scale was based upon the severity of need for services and potential for improvement. This is unlike other available scales which emphasize severity of disability. The scale utilizes a point system to classify students from those with a high priority for therapy down to those requiring classroom consultation only.

In addition to the rating scale, a numerical method of determining a maximum, optimal therapy caseload was developed. Caseloads were determined based upon the number of students at each severity rating level. The severity of need rating scale coupled with the method of determining optimal therapy caseload helps facilitate a more equal distribution of work load among therapists in a school. Additionally, it can provide hard evidence that more therapy services are required in a particular school system.

Both the rating scale and the caseload recommendations have been field tested and the data analyzed. The data provides support for the appropriateness of the rating scale and caseload recommendations when used in conjunction with the therapist's professional judgment. The described method of determining need and caseloads can be used in any school system. However, because of different resources and varying degrees of compliance in providing related services, modifications must be made to best meet individual needs of any school system.

Severity of Need Determinations

The rating scale is based upon the severity of need for services and potential for improvement. The child is given points for those factors that would increase his likelihood of benefitting from therapy and points

are subtracted for those factors which would hinder his benefitting from therapy. The scale is intentionally biased towards the younger, less impaired child. However, with slight modifications of the points or items listed, the scale can be adapted to reflect different critical factors.

Children requiring direct therapy are classified according to the nature and severity of need for therapy intervention.

High Priority

Children with a severe need for therapy are those children whose broad educational program will receive significant direct benefit from therapeutic intervention, and whose prognosis for improved function is excellent to good. Children with a severe need for therapy generally, though not always, include the following:

1. Youngest of served population.
2. Those who have not yet received therapy services.
3. Those who displayed potential for increase function.
4. Those with a recent diagnosis or disability.

Maximum caseload: 13-14 students (1.5 contact hours per student per week).

Moderate Priority

Children with a moderate need for therapy are those children whose broad educational program will receive some direct benefit from the therapeutic intervention and whose prognosis for increased function is good to fair or unknown because of no previous therapy. Children with a moderate need for therapy generally, though not always, include the following:

1. Younger children.
2. Those ready to achieve a new developmental or functional level.
3. Those who have shown direct benefit from therapeutic intervention.

Maximum caseload: 20 students (one contact hour per student per week).

Low Priority

Children with a mild need for therapy are those children whose broad educational program might receive limited benefit from the therapeutic intervention and whose prognosis for improved function is fair to poor.

Children with a mild need for therapy generally, though not always, include the following:

1. Older children who have plateaued either developmentally or functionally.
2. Those who have received previous therapy.
3. Those whose prognosis for successful function does not depend upon the therapeutic intervention.

Maximum caseload: 40 students (30 minutes per student per week).

Indirect Services

Programming is planned by a therapist and administered by another person (parent, teacher, or assistant) with periodic monitoring by the occupational or physical therapist. Indirect services would include instruction to classroom personnel in procedures required for daily management for a specific student.

Caseload Determinations

Caseloads must be determined based upon the travel time, consultation, set up, equipment construction, report writing, inservice, staffings, meetings, etc. Time for these activities must be allocated before the amount of time for direct therapy services is determined. Additionally, extra time at the beginning and end of the school year must be allowed for screening, evaluation, contacting physicians, etc. Many systems allow a complete month without treatment at the start and end of the school year for these activities. In Georgia, after the initial month of organization and consultation, it was determined that the average staff therapist, working full time, had approximately 20 hours per week available for direct treatment. This was divided into 40 30-minute units. The number of therapy units for each child is determined as follows:

Determining Maximum Caseload

Total units: 40 (20 hours per week)
Determine number of units for each child:

High priority student	-	3 units (1 1/2 hours per week)
Moderate priority	-	2 units (1 hour per week)
Low priority	-	1 unit (1/2 hour per week)
Indirect service	-	1/4 unit (1/2 hour per month)

Determine total number of units for all children on caseload. If total is greater than 40, enroll high priority students first, then moderate, and low.

Example #7

County of Los Angeles
California Children Services

Determining Amount of Therapist Time Available for Patient Services

1. 8 1/2 hour day, less 1/2 hour for lunch and 1/2 hour for break: 37.5 hours

2. Assessment time (used to determine the needs of new patients)
   1 hour per week (CCS) - 1 hour
   (5 hours per week - O.T. Forum) 36.5 hours

3. Staffings and meetings
   1 hour per day, 5 hours per week - 5
   31.5 hours

4. Documentation
   1 hour per day, 5 hours per week - 5
   26.5 hours

Using this model, staff therapist would have 26.5 hours available for patient services. Travel time must be deducted from the hours available for patient services. 26.5 less 6.5 hours for travel = 20 hours PT service.

Determining Amount of Therapist Time Needed to Cover all Patient Needs

A Patients	B Patients	C Patients
1. Tammy = 1.5 hours 3X wk. for 1/2 hr.	Group of 4 PTs 4X wk. for 1 hr.	Actual time = 1/2 hr./child needed per month
2. Mike = 1 hour 2X wk. for 1/2 hr.	Supervision of each patient receiving indirect service = 1/2 hr./child	

3. Joe = 2 hours
2X wk. for 1 hr.

150 hrs./wk.	40 hrs./wk.	15 hrs./wk.

150
40
15
205 hours/week therapist time needed

205 hours to meet patient needs divided by 20 hours therapist time available for patient services, need is for 10 therapists.

Example #8
American Occupational Therapy Association's
Suggested Formula for Determining OT/PT Caseload

OT/PT Evaluation Results	15 min/week consultation to teacher(s)	30 min/week/child & 15-min consultation to teacher(s)	Two 30 min/week sessions and 15-min consultation to teacher(s)	Minimum three 30 min/week sessions and 30-min consultation to teacher(s)
1. Total patterns of movement	Near Normal	Reflex/reactions slightly evident	Define reflex/reactions and/or definite poor postural muscle function	Definite abnormal patterns of posture and movement may totally interfere with development or significantly delay development
2. Age-appropriate gross motor skills (includes evalu a-tion of quality of movement)	Within 1 year	1-2 year delay in 75% activities	More than 2-year delay in 75% activities	More than 3 years, or not applicable
3. Age-appropriate fine and visual motor skills (in cludes evaluation of quality of move ment)	Within 1 year	1-2 year delay	More than 2-year delay	More than 3 years, or not applicable
4. Muscle tone	Normal	Slightly hypotonic or hypertonic	Definite indication of hypotonicity or hypertonicity	Abnormality definite
5. Oral motor involvement	None	None	None	None
6. Prognosis		Should respond to intervention in 1 year's time	Prognosis varies according to problem: progress is slow. Intervention most effective K-2. Long-term intervention indicated throughout elementary years.	Will need some type of therapy service throughout elementary years to prevent deformity and/or permit participation in school activities.

From "Training: Occupational Therapy Educational Management in Schools" developed by the American Occupational Therapy Association, Inc. Supported by Grant #G007801499 from the Department of Education and Rehabilitative Services.

APPENDIX F

TERMINOLOGY

Terminology

COMMONLY USED TERMS AND DEFINITIONS:

ACCESSIBILITY: Lack of physical barriers within the environment which may prohibit access to individuals with physical disabilities, e.g., stairs, narrow doorways.

ADAPTIVE EQUIPMENT: Equipment designed to make a particular function easier such as buttoners to assist in buttoning, spoons with built-up handles.

ASSISTIVE EQUIPMENT: Equipment designed to assist the student with a particular function such as walkers, crutches, etc.

AUTOMATIC BALANCE REACTIONS: Normal, often subtle responses to positional changes which allow the body to remain upright and functional against gravity.

CATHETERIZATION: A method used by individuals who lack bladder control (some spina bifida, spinal cord injuries) to empty the bladder at periodic intervals.

COCONTRACTION: Simultaneous contraction of the muscle groups on all sides of a joint to provide stability.

CONTRAINDICATION: Any condition of the disease which makes the indicated treatment inadvisable.

CONVERGENCE: Movement of the eyes toward the same point.

DEVELOPMENTAL SEQUENCE: The development of movement and strength on both sides of the body as an infant comes up against gravity from supine to prone to quadruped to kneeling, standing and then walking.

DIVERGENCE: A visual separation from a common center.

DOMAINS: Functional environments such as:

HOME
SCHOOL
COMMUNITY (INCLUDING LEISURE AND JOBSITE)

FINE MOTOR: Skills pertaining to the synergy of small muscles, primarily in the hand, and related to manual dexterity and coordination.

GENERALIZATION PROCESS: The ability to take a learned task or skill and translate it to a different area or environment and accommodate with appropriate changes such as walking in the therapy room to walking in a classroom or home.

GOAL: A global functional expected outcome.

GROSS MOTOR: Skills pertaining to the synergy of large muscle groups, as in balancing, running and throwing.

HEAD CONTROL: Development of the synergistic muscle groups of the neck which allow the infant to hold its head up against gravity and move it in all directions.

KINESTHESIA: Ability to perceive the extent of movement or direction or weight of movement.

KYPHOSIS: Exaggeration or angulation of normal posterior curve of the spine. Gives rise to condition commonly known as humpback or hunchback. Also refers to excessive curvature of the spine with convexity backward.

LORDOSIS: Abnormal anterior convexity of the spine.

MOBILITY: Manner of independently moving from place to place (walking, running, wheelchair, crawling).

MUSCLE TONE: Readiness state of the muscle to respond to a stimulus. It may be high, low, normal or fluctuating.

MOVEMENT PATTERNS: Development of normal movement patterns includes the infant moving through the developmental sequence, against gravity, to come to stand and walk. This includes the development of normal righting, equilibrium and protective reactions.

The development of abnormal movement patterns occurs when the child is 'driven' to come up against gravity without the benefit of synergistic (working together) muscle control and the development of the normal righting, protective and equilibrium reactions.

NEUROLOGICALLY INVOLVED: Student is diagnosed with a disorder which primarily involves the dysfunction of the central nervous system.

OBJECTIVES: Short-term functional outcomes.

ORTHOPEDICS: Branch of medical science dealing with prevention or correction of disorders involving locomotor structures of the body, especially the skeleton, joints, muscles, fascia and other supporting structures such as ligaments and cartilage.

ORTHOSIS: Straightening or correction of a deformity or disability.

ORTHOTICS: Use of external bracing to correct a deformity or disability.

PROPRIOCEPTION: Awareness of posture, movement, and changes in equilibrium and the knowledge of position, weight, and resistance of objects in relation to the body.

STEROGNOSIS: Ability to identify shapes through the tactile sense.

SCOLIOSIS: Lateral curvature(s) of the spine.

TACTILE: Sense of touch.

APPENDIX C

LIST OF TESTS

FREQUENTLY USED EVALUATION TOOLS*

The following list includes evaluation tools used primarily by occupational and/or physical therapists.

De Gangi-Berk Test of Sensory Integration (TSI) (ages 3-5 years). Measures three subdomains of sensory integration: postural control, bilateral motor integration, and reflex integration. Used to identify children with delays in sensory, motor, and perceptual skills.

The Erhardt Developmental Prehension Assessment (EDPA) (ages 0-6 years). A series of protocol sheets which evaluate prehension through developmental sequence clusters. It looks at transitional skills as well as pattern components which lead to final skills.

Hughes Basic Gross Motor Assessment (BGMA) (Ages 6-12 years). A standardized test of gross motor functioning based on performance of normal students. Norms are included for the special education population as well.; Evaluates gross motor abilities considered basic to the development of higher-level skills. Scoring is detailed to asses the quality of movement.

Miller Assessment for Preschooler (MAP) (Ages 2 years, 9 months - 5 years, 8 months). Tests a child's developmental status with respect to other children of his/her age. It specifically tests basic motor and sensory activities, complex fine and oral motor abilities, cognitive language abilities, cognitive nonverbal abilities, and skills requiring an interaction of sensory, motor, and cognitive abilities.

Peabody Developmental Motor Scales (Ages 0 - 7 years). A criterion based checklist of gross and fine motor skills based on normal sequential developmental milestones. Five criteria, ranging from total dependence to complete independence in performing tasks are provided for rating a child's performance on each item.

The Revised Gesell Developmental Schedules (Ages 4 weeks to 3-4 months). Provides behavioral assessments in the areas of adaptive, gross motor, fine motor, language and personal-social behavior in an attempt to identify even minor deviations in children and to determine the maturity and integrity of the central nervous system.

Sensory Integration and Praxsis Test (SIPT) by Ayres (ages 4 - 10). Tests a child's sensory integration.

Tests of Visual Perceptual Skills (TVPS), by Morrison and Garner (ages 4 - 13 years). A non-motor assessment of a child's visual -perceptual skills. Results give perceptual quotient, percentile, and median perceptual age on the following subtests: visual discrimination, visual-spatial relationships, visual form constancy, visual figure-ground, visual memory, visual closure, and visual sequential memory.

The following evaluation tools are those which are often used by other disciplines, as well as by therapists, although results may be analyzed from different perspectives.

Brigance Diagnostic Inventory of Early Development (Ages 0 - 7). Determines developmental or performance level in the following skill areas: fine and gross motor, self-help, speech and language, general knowledge and comprehension, and early academics. Identifies areas of strength and weakness and instructional objectives.

Bruininks-Oseretsky Test of Motor Proficiency (Ages 4 - 14)). Gross and fine motor subtests which include running speed, control and upper limb speed and dexterity.

Developmental Test of Visual Motor Integration (VMI), by Keith E. Beery and Normal A. Buktenica (2 forms: A - ages 2 - 8 years; B - ages 2 - 15 years). Tests of integration of visual perception and motor behavior in children.

The Motor Free Visual Perception Test (MVPT), by Colarusso and Hammill (Ages 4 - 8 years). A test of visual perception which avoids motor involvement. There are 36 possible responses categorized in areas of spatial relationships, visual discrimination, figure-ground, visual closure, and visual memory.

*Waukesha Delivery Model: Procedures Manual

APPENDIX H

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